MAY-JUNE, 1958

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, an occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.
2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.
4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 10 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

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INVENTORY

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RALEIGH, N. C.

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News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

BOSTON: The Ninth Annual Conference on Alcoholism was held Tuesday, May 6, at John Hancock Hall. Subject of the Conference was "Alcoholism's Unfinished Business." Among those participating in the Conference were two outstanding experts on alcoholism; Dudley P. Miller, President of the North American Association of State Programs on Alcoholism and Dr. Marvin A. Block, Chairman of the American Medical Association Council on Mental Health-Committee on Alcoholism.

RALEIGH: The Scholarship Committee of the ARP has announced that 23 North Carolinians have been chosen as recipients of scholarships to the 1958 Yale Summer School of Alcohol Studies. This makes a total of 190 persons living in the State who have received scholarships to the Yale School since 1950—a record to be proud of. Also for the seventh consecutive summer some member of the ARP staff will be part of the Yale lecturing staff at the summer school. This year, S. K. Proctor and Norbert L. Kelly will be on the faculty.

NEW HAVEN: An Alumni Institute of the Yale Summer School of Alcohol Studies will be held in New Haven from July 27-31. Ernest Shepherd, Executive Director of the Florida State Program is chairman of the program committee. North Carolinians on the committee are Norbert L. Kelly of the ARP and Annie Ray Moore of the N. C. Department of Education. Alumni returning for the Institute will meet in small workshop groups for most of the sessions. The theme of the Institute is "Facts and Factors Influencing Public Attitudes Toward Alcohol and Alcoholism, 1948-58."

GREENSBORO: The Greensboro Council on Alcoholism was host to several hundred professionals and lay persons at their "Alcoholism Education Week", April 28-May 2. The Week included special programs for ministers, nurses, industrialists and educators who were interested in learning more about alcoholism. The ARP participated in the Week by co-sponsoring with the three state nurses's associations, the 1958 Nurses' Institute on Alcoholism. Over 130 nurses were in attendance. National figures attending and speaking at the week-long programs were Dr. Ruth Fox, Vice-President of the National Council on Alcoholism, Marguerite Vollmer, Lecturer in Health Education at Columbia University, Rev. Ernest A. Shepherd, Director of the Florida Alcoholic Rehabilitation Program, and Dr. Anthony Zappala, former chief of the District of Columbia Alcoholic Rehabilitation Program. Participants and speakers from the ARP were S. K. Proctor, Norbert L. Kelly and Miss Roberta Lytle.

RALPH M. HENDERSON

(1895-1958)

WE were saddened to learn of the death of Ralph M. Henderson, esteemed member of the staff of the Yale Center of Alcohol Studies, on April 5 in New Haven, Connecticut.

Mr. Henderson, affectionately known as "Lefty" to thousands, was a successful lawyer and industrialist before joining the Yale Center in 1949 as industrial consultant. In that capacity he became a nationally known authority on the control of alcoholism in business and industry.

Dr. Selden Bacon, Director of the Yale Center, paid him this fitting tribute:

"Lefty will be remembered by his thousands of friends and admirers not only for his wonderful sense of humor but for his deep conviction that alcoholics can be helped. His lectures at Yale and across the country, his work with legislatures, industries, and community groups, and his memorable personality, played a most significant role in awakening the country and in initiating responsible programs to meet an age-old problem."

A memorial to Lefty has been established jointly by the Yale Summer School of Alcohol Studies and those who wish to participate. The memorial consists of a full fellowship to the Summer School, to be known as the Ralph M. Henderson Fellowship. This will be awarded to a qualified candidate for admission who needs financial assistance to attend; preference will be given a recovered alcoholic. Anyone wishing to contribute to this memorial should make their donation to the Yale Summer School of Alcohol Studies and send it with a note to Dr. Bacon, Center of Alcohol Studies, 52 Hillhouse Avenue, Yale Station, New Haven, Connecticut. The first award for a student at the 1958 session will be announced at the Alumni Institute to be held in July.

Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

At the recent annual meeting of the North Carolina Conference of Social Service, held in April, the following resolution was enacted:

WHEREAS, reliable statistics indicate that there are at least 60,000 alcoholics residing in the state of North Carolina

WHEREAS, this widespread social and public health problem adversely affects all of the major social institutions in North Carolina

WHEREAS, the necessity for supporting the families of many alcoholics through various community welfare agencies places an added strain and burden on our welfare and relief funds

WHEREAS, the illness of alcoholism might be ameliorated through a more adequately supported program of research, treatment and education

And, WHEREAS, income to the General Fund of North Carolina resulting from the sale of alcoholic beverages exceeds 8 million dollars per year,

BE IT, THEREFORE, RESOLVED THAT

The North Carolina Conference for Social Service do endorse the program of the North Carolina Hospitals Board of Control for research, treatment and education with respect to alcoholism as embodied in the North Carolina Alcoholic Rehabilitation Program.

And, that the conference take appropriate steps to help obtain essential financial and legislative support to implement its program.

We feel that this resolution will be of great help to the ARP during the next legislative session, to be held beginning next winter, and are very pleased that the N. C. Conference of Social Service saw fit to endorse the work of our program. Perhaps this resolution will stimulate other organizations in the state concerned with public health problems to adopt a similar platform. With the combined strengths of several organizations and the ARP, we have no doubt but that the 1959-60 legislature will give our appropriation request a sympathetic hearing.

Recipients of the scholarships to the 1958 Summer School of Alcohol Studies to be held June 28 - July 24 at Yale University have been announced. Those from North Carolina who were granted scholarships by the ARP will be announced in the next issue of INVENTORY.

VOL. VIII, NO. 1 INVENTORY MAY-JUNE, 1958

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

A NATIONAL EMERGENCY

BY WILLIAM C. MENNINGER, M.D.

From an address to the National Council on Alcoholism, appearing in the June 1957 issue of the MENNINGER QUARTERLY. Reprinted by permission.

IN our country alone there are over 4,500,000 problem drinkers — an astounding figure which represents more than 2 percent of our population. Even that does not state the total size of the problem. We do not know the extent of alcoholism's role in the enormous and increasing numbers of accidents and crimes, nor the effect on the families and friends of this huge group of people.

Studies by a number of companies show why alcoholism can truthfully be called the"billion dollar hangover" in industry. For instance, the problem drinker:

> loses, from the effects of alcohol, 22 working days a year more than the average employee;
>
> loses, from other illnesses, another two days a year more than the average of other employees;
>
> has twice as many accidents as the non-alcoholic.
>
> has a life expectancy 12 years shorter than the non-alcoholic.

One thoughtful estimate of the cost of alcoholism—including wage loss, crime and delinquency, accidents, hospital and medical care—is $800,000,000 a year. Yet the financial costs are trivial compared to the heartache, suffering, and distress so many people suffer because of alcoholism.

A startling paradox is the pittance of money and effort devoted to changing this picture. The National Council on Alcoholism, for example, operated on a budget of $204,000 the past year and will have only an estimated $302,00 available in 1957. That

won't lick an $800,000,000 problem. The further tragedy is that the incidence of alcoholism is definitely increasing. So will the cost.

Why has this problem grown so enormous? It may be due in part to our failure to understand each other. Only 200 years ago, anyone who acted strangely was believed infested with witches or animal spirits. Even in 1957 most of us have a low degree of tolerance toward deviate behavior in anyone else. It is so easy to call names or fix labels on another person's behavior without making an attempt to understand what is going on in his mind to make him behave the way he does. Mentally ill people are still stigmatized, even after they have recovered. Similarly, those who suffer from the mental illness called alcoholism are stigmatized. By and large alcoholism stimulates disgust, fear, contempt, anger, hostility, or resignation, rather than constructive action.

A Psychological Symptom

I say alcoholism is a mental illness for, as a psychiatrist, I believe excessive drinking is a psychological symptom related to deep, unconscious, emotional conflicts. This does not deny the possibility of organic or chemical causes; certainly there are inevitable organic changes from long-time drinking. There are many types of excessive drinkers, and also many different types of personalities which become incapacitated by excessive alcohol. But in each case it results from disturbances of the individual's aggressive drive. He is unable to control and handle the instinctive hostile feelings that are a part of the make-up of every personality. Instead of channeling his aggressive feelings to constructive use, the alcoholic simultaneously directs his hostility towards himself and his environment.

What has been done to combat this monstrous problem? The law has been and still is the common "treatment" meted out to the alcoholic by our social order, but it only hides the problem and does not solve it. The moralistic approach of regarding drinking as a matter of "sin" still is without tangible success in modifying the onward march of excessive drinking. Some progress—though really only a beginning—has been made since 1930. Alcoholism began to be recognized then as other than a moral problem.

What was to become the Yale Center for Alcoholism's Studies began at about that time. It today is an outstanding organization whose research, educational, and consultative efforts are largely responsible for many recent advances toward recognition of the alcoholism problem.

Alcoholics Anonymous began in 1935 and now has an estimated 200,000 members of more than 5,000 local groups. AA has been the most successful approach to alcoholism to date.

In 1937 the Research Council on Problems of Alcoholism was established to emphasize the medical attack on the problem, and it fused with the National Research Council in 1949.

The Yale Clinic gave impetus to the establishment of the National Council on Alcoholism in 1944. As the national voluntary health agency in this field, the National Council is probably the most constructive force in this country to face the problem. Still it has had to wage an up-hill struggle in finding leadership and financial support.

The Industrial Medical Association founded a committee on problem drinkers in 1947. The American Psychiatric Association established a

committee on alcoholism in 1948; that committee is now a part of the APA committee on public health. The American Medical Association established, as part of its committee on chronic diseases, a subcommittee on the problem of alcoholism in 1951. Eight state medical societies now have special committees on alcoholism.

Industry has taken a growing interest in the problem. Many large firms have taken it upon themselves to organize treatment facilities for their employees. Fifteen of them in the New York City area, under the leadership of Consolidated Edison Company, have combined their efforts.

Interest Growing Elsewhere

The pioneering of many communities is best illustrated by the Portal House in Chicago. Also to be commended is the increase in the number of general hospitals that now accept cases of alcoholism for treatment—instead of sending them to jail. In 1944 that was done in only 96 general hospitals; in 1956 over 3,000 did so. Many of our states, too, are showing increasing interest. More than 30 now have official government commissions on alcoholism.

Yet with all these programs, we have only touched the surface of what could be accomplished. Psychiatry, for instance, has had some successes through Antabuse, conditioned reflex therapy, group therapy, and individualized therapy. All of these have helped some people, but proportionately only a small percentage. Psychiatric research such as that carried on for the past five years at Winter VA Hospital is learning a few answers but we must dig and dig for more.

What needs to be done? We have to look at alcoholism as a health problem, a social problem, and a legal problem as well as a moral problem. It touches and overlaps into all these areas of life. I should stress four points:

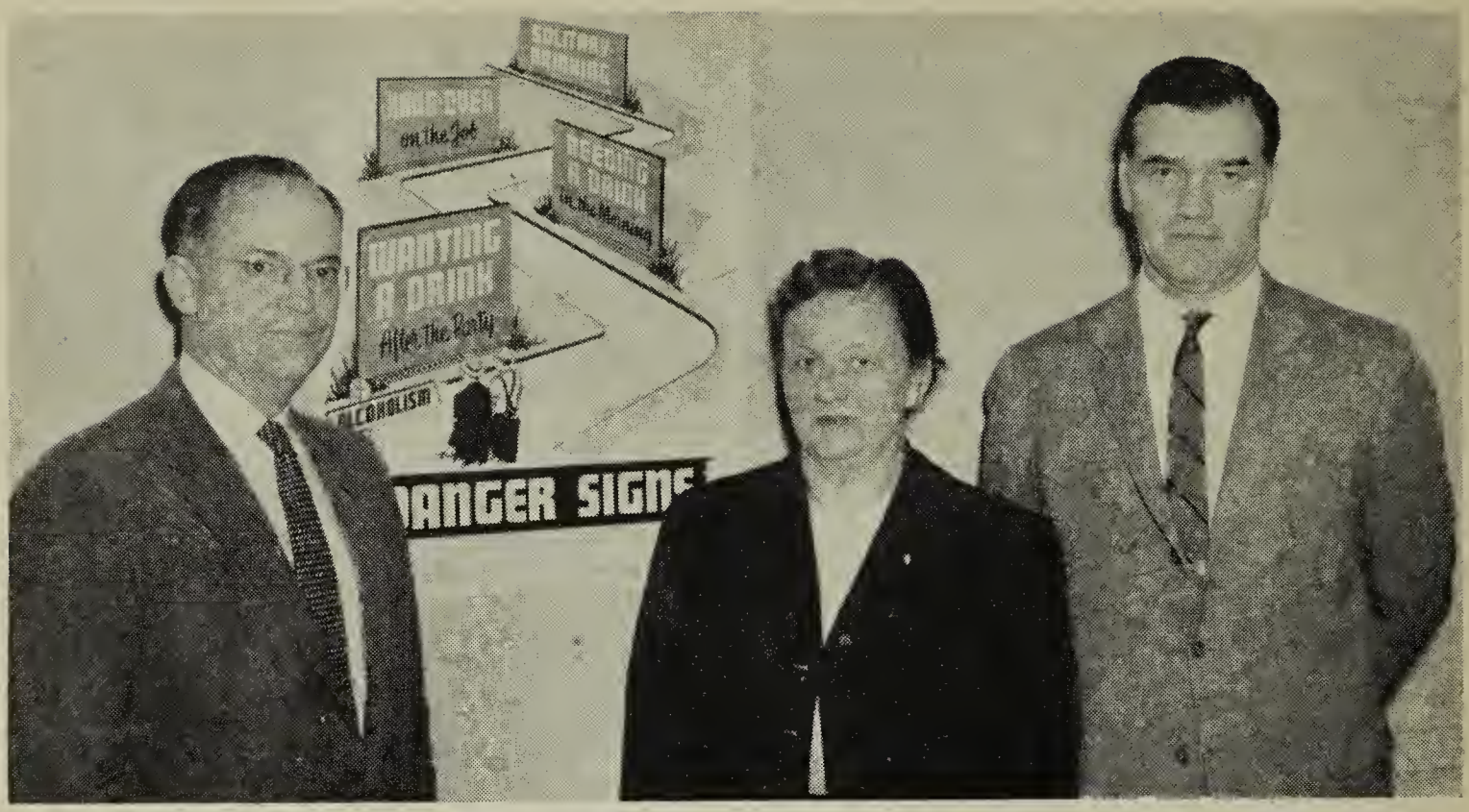
1. *Public education.* We must make much more use of mass communication media in an educational effort to help people understand alcoholism. Too many look upon this illness as lack of will power. Unless we can help them understand that the problem really is a sickness, we are not going to change their attitudes toward it and promote public efforts for preventive education. Through the promotion of groups within communities to educate, interpret, establish information centers, and promote clinics, it will be possible to make such forward steps as the wider acceptance for short-term treatment in all general hospitals. The nature of the problem must be taught in our schools and colleges—to the professional student as well as the layman. Unfortunately the term "alcoholism" is rarely mentioned in most of our medical schools.

2. *Research.* We must have new knowledge of the causes, prevention, and treatment of alcoholism.

3. *Professional training.* We don't have nearly enough people trained to do the diagnosis, treament, and prevention which must be done.

4. *Facilities for treatment.* To do the job we must have adequate facilities so that the fruits of research and professional training can be put to work.

If alcoholism were a communicable disease, a national emergency would be declared. We do have a national emergency. It is our privilege and opportunity—our responsibility—to go forward with the solution of this problem of alcoholism with more intensity and dedication and determination than ever before.



Council officials are (l. to r.) Dr. Thomas T. Jones, President; Mrs. Olga Davis, Secretary-Treasurer; and Phillip M. Bolich, Vice-President

The Durham, N. C. COUNCIL ON ALCOHOLISM

A community bands together and helps to solve its own alcoholism problem.

BY GEORGE ADAMS

TO the many citizens who have nurtured it from an idea to reality, the new Alcoholism Information Center in Durham, North Carolina, is a satisfying result of community effort and cooperation.

Located at 209 Snow Building in mid-town Durham, the Information Center is open to anyone—whether an alcoholic, his friends, or spouse—who may feel the need of its unique kind of help.

The Information Center is slated to become the hub of activity in a well-planned program of alcoholism education, rehabilitation and research being launched by the Durham Council on Alcoholism, a volunteer citizen's group. Heading the Executive Committee of the Council is Dr. Thomas T. Jones, esteemed Durham physician and chairman of the alcoholism sub-committee of the State Medical Society. Mr. Philip M. Bolich, local insurance man is vice-president.

A twenty-four member Board of Directors, made up of prominent citizens, serves in an advisory capacity to the Executive Committee.

Already, in only three months of operation, the Information Center has had many visitors. Some have

been merely the interested or curious who want to find out what an alcoholism information center looks like and what it does. Others have sought help for their own alcoholism problem or that of a close family member. All express surprise and pleasure with what they see and learn.

The first thing one sees upon entering is an attractive outer waiting room, suggestive of a physician's office. There are comfortable chairs and a full literature rack to encourage browsing. The inner offices are adequately furnished with an executive desk, conference table and chairs, and several more tables of alcoholism literature. About the place there is a pleasing, cheerful atmosphere—colorful curtains at the windows, harmonious pictures, growing plants. Behind such fixings there is usually a woman's influence, and the Center is no exception. The distaff side is represented by Mrs. Olga Davis, under whose full-time supervision the Information Center operates. Mrs. Davis is a former county welfare department worker, veteran of eight years service there. In addition to her duties at the Center, she is also Secretary-Treasurer of the Durham Council on Alcoholism.

Mrs. Davis' job and that of the Information Center is to act as a master switchboard, talking with alcoholics and their families, and then putting them in touch with community resources and agencies which are in best positions to help. Requests to the center for aid may be handled in any of a number of different ways. If the caller is the wife or husband of an alcoholic, he or she may be invited to come in for a chat. Mrs. Davis will give the spouse a chance to ventilate pent-up feelings, suggest possible sources of help, supply some instructive literature, and invite a return visit when necessary. Sometimes just this is enough to effect a change in the home atmosphere which may help motivate the alcoholic toward treatment. Or at least it *may* lead to some improvement in the drinking pattern.

When help for an acutely ill alcoholic is requested, Mrs. Davis is likely to refer the caller to one of the ten Durham physicians who have volunteered to give time to an alcoholic patient who needs it. In re-

Mrs. Olga Davis, on full-time duty at the Information Center, talks with alcoholics and their families, suggests rehabilitation channels.

sponse to other calls for assistance, she will refer to a similar list of ministers who have volunteered for counseling services, or perhaps to members of Alcoholics Anonymous. It all depends on the individual need as to which course of action Mrs. Davis will recommend. Her long experience with the Welfare Department plus her warm and accepting personality help her immeasurably in recommending what is best for each individual.

Direct help for the alcoholic and his family is not the only purpose of the Information Center. "The public must be taught that alcoholism is a disease," says Mrs. Davis. "We do not take a stand on the wet or dry question. Our job is to *educate* people." Furnishing free literature and study materials is an important part of this educational process. A speaker bureau has been formed, so that people well versed in alcoholism topics can be readily engaged to speak before civic, church and school groups throughout the community. Instructive films are available for free public use.

Other Developments

The Center also expects to develop a number of seminars and workshops for various professional groups in the community, and to expand its program of education in the schools. Already, the Council enjoys an excellent relationship with the local mass communication media—radio, TV and newspapers. Every effort will be made to keep a steady flow of accurate information going to the public through these channels.

Dr. F. Scott Gehman, chairman of the Council's committee on rehabilitation, reports that a definite program of rehabilitation is taking shape. Group therapy meetings for alcoholics, held in Dr. Jones' office, have been in progress for some time, under the supervision of physicians and psychologists. Under professional direction, group discussions with alcoholic prisoners in the county workhouse are being conducted. Recognizing the tremendous influence of Alcoholics Anonymous, the council's philosophy of rehabilitation is permeated with AA principles. AA members, too, are personally involved in the rehabilitation work. Many have volunteered to help with alcoholic patients whenever they are needed.

Dream Becomes Reality

A weekly alcoholism clinic, with facilities in a general hospital, is a dream now nearing fruition for the Council. Plans call for the clinic to be located in Watts Hospital. Here the disciplines of medicine, nursing, and social work will be coordinated in a program of group therapy to benefit alcoholic patients who honestly wish help.

The Durham Council is unique, in that up to now it has not had to conduct any organized solicitation for funds. The budget for the first year of operation will run between $5500 and $6000—all of which will be provided by "friends" and anonymous donors in the community. Next year, the budget will likely run up to $7500. According to Dr. Jones, no public campaign for funds is in the immediate prospect. "We do, of course, welcome private donations from interested individuals," he says, adding that the Council has recently been incorporated as a legitimate nonprofit organization.

An Outgrowth

The Durham Council on Alcoholism is an outgrowth of events dating back to 1954-55, when the State Junior Chamber of Commerce adopted alcoholism education as a state-

wide project. The Durham Jaycees were particularly active in this project on the local scene. They helped stimulate an official Alcoholism Education week in Durham, and sponsored a widely publicized speaking engagement by Mrs. Marty Mann, Executive Director of the National Committee on Alcoholism.

Committee Formed

The Jaycees' intense activity helped to concentrate local interest. As a result, a provisional Citizens' Committee on Alcoholism was formed, headed by Dr. Jones and Jaycee Robert S. Peake. This committee, operating under the supervision of the Durham Planning Council, undertook a survey of local physicians, industrial plants, social agencies and other professional groups to determine the extent of alcoholism in the Durham area. They found that, as in every community, the problem was prevalent and the need for corrective measures considerable. The interim Citizens' Committee served until January, 1958, when the present council was established.

The Durham Council on Alcoholism represents a *community* effort to alleviate some of the suffering caused by alcoholism. In fittingly idealistic terms, Dr. Thomas Jones summarizes the Council's motivations this way:

"Regardless of dates, personalities, specific events, or the contribution of any faith, individual, organization or administrative element, the formation of the Durham Council on Alcoholism is essentially the result of man's feeble but continuing effort to make restitution for man's inhumanity to man. It is also essentially the result of increasing recognition of the dignity of the individual, and the inherent nobility of the soul, without prejudice and without criticism."

THE ALCOHOLIC OBSERVED

THE majority of chronic alcoholics have an unusual amount of anxiety or tension that they attempt to control by drinking; this anxiety is experienced as a feeling of fear, dread, or apprehension that may amount to panic. Most anxious patients control their tension by the development of some one of the psychoneurotic reactions. The alcoholic on the other hand may develop few somatic complaints to control his anxiety, which he tolerates poorly and attempts to relieve immediately by drinking; this is a temporarily effective measure.

THERE are various reasons for alcoholics' deciding to cease drinking. Most frequently the necessity of abstaining does not originate with the alcoholic but is imposed upon him. Such factors as the threat of losing his job, being divorced, or being prosecuted for driving while intoxicated motivate an apparently spontaneous decision to stop drinking. Unfortunately, when the outside pressures are relieved, the patient's resolve is likely to fade and his previous drinking pattern will be resumed, unless the anxiety over the results of further drinking is greater than the impulse for immediate relief of tension.

—Jackson A. Smith, M.D. in AMA JOURNAL

Problem Drinking and Community Responsibility

Reprinted by permission from the April, 1958 issue of PASTORAL PSYCHOLOGY

ALCOHOLISM and problem drinking are of social concern primarily because of the many, many ways in which they inflict a tragic mark upon society. Whether considered from a personal viewpoint, from a family viewpoint, from the viewpoint of the church, the schools, industry, or from that of the community at large, the costs of alcoholism are immense.

In respect to family relations it is known that the alcoholic is almost always a difficult person with whom to get along. Often the same characteristics which make him prone to excessive drinking also make him unsuited for family living. The family demands a giving of oneself, sharing personal and emotional experiences, giving and receiving of affection, prestige, self-respect. All this is particularly true with the growing complexities of life in specialized society, for more and more the family is becoming the only medium by which the individual can achieve these personal gratifications. Yet the alcoholic is often a person who is incapable of sharing gratifications on an intimate personal level or who has not learned how to do it. Furthermore, he frequently will make completely unreasonable and unrealistic demands of those around him. To these difficulties in personal relationship which threaten the stability of any marriage involving a problem drinker, must be added the costs of unhappiness, the unwholesome effect on children, the drain on the family's financial resources, and many other factors which in the long run spell misfortune.

Even Greater Costs

From the point of view of the community at large there is an even greater picture of costs due to problem drinking. Not only does the community stand to lose from such factors as marital discord but, in addition, the community spends large amounts of money in what has, to the present time, been a futile effort to do something about the problem of alcoholics. There are always a considerable number of alcoholics who have gone so far that they no longer can hold any type of steady employment. And so the community has to step in through its charitable agencies and support these people and their families. Other problem drinkers find themselves without family or friends and often without the price of a bed or a meal and these too become the charges of charity. Many others, either as vagrants or because of their disorderly behavior, come into the arms of the law. There are parts of the country where ninety-five percent of the cells in local jails are occupied by people appre-

hended because of drunkenness. The community, too, eventually stands to pay the costs of accidents due to alcoholism.

The costs of alcoholism to a community's industry and business must also be considered in terms of such factors as periodic absenteeism of the alcoholic during or following a bender, the waste of materials; the loss of efficiency and in some cases resulting slow-down of an entire production line; the higher accident rate of alcoholics with its effect on safety standards and again on production and costs for medical and hospital expenses as well as disability and pension payments. There are also costs due to rapid rate of labor turnover when it becomes necessary to fire alcoholics from their jobs, and the detrimental effect which the alcoholic in an organization may have on the morale of his fellow workers or associates is not inconsiderable.

With problem drinkers whom society feels it must retain in custody, there have been traditionally only two courses of action: the jail and the mental hospital. Both of these are extremely costly and neither has afforded any opportunities for getting at the roots of the problem. Millions of dollars are wasted annually in putting alcoholics away for a time—keeping them forcibly from drinking —only to have them go on bigger benders when released. Most jails and

The problems of alcoholism are felt in all of the major institutions in our society: the family, religion, education, health, government, and in business and industry.

BY ROBERT STRAUS, PH.D.

the average mental hospital cannot give the alcoholic the medical or psychiatric treatment or social guidance which is needed to get at the roots of his illness.

One could go on citing the costs of alcoholism for a long time—nothing has been said of the costs to the individual in terms of his poor health, unhappiness, and the fact that his life inevitably becomes pretty much of a mess. However, it should be clear that alcoholism is a tremendous social and public health problem.

It is important that a clear-cut distinction be maintained between alcoholism and drinking. The use of alcoholic beverages is a form of custom. The use existed before the beginnings of recorded history and has been widespread, with considerable variance, in time and culture. In the United States at present from sixty-five to seventy million adults customarily use alcoholic beverages at some time. Among these sixty-five million people there are perhaps four and one-half million problem drinkers—persons for whom drinking is associated with severe problems of adjustment. These include both alcoholics and those persons who, although they maintain control over their drinking, find that it interferes in varying degrees with their health and personal relations and materially reduces their effectiveness in work and other activities. Alcoholism itself can be defined as a complex aggressive disorder characterized by the uncontrolled use of alcohol and by various symptoms of psychological, physiological, or social maladjustment.

In considering the underlying causes of alcoholism, factors of personality development and of environment should be included. In addition, the possible existence of a physiological factor or factors should be considered as a limiting or primary cause. Major etiological importance is attached to the effect of early environmental factors on the development of the pre-alcoholic personality, for the alcoholic is usually characterized by the survival of immature

MEET THE AUTHOR

Dr. Robert Straus received his Ph. D. from Yale in 1947, after which he spent 6 years on the staff of the Yale Center of Alcohol Studies. During this period he also served as acting director for the Connecticut Child Study and Treatment Home and as staff director for the Connecticut Commission on Health Resources.

In 1953 he went to the State University of New York, Upstate Medical Center in Syracuse, as assistant professor and then associate professor of preventive medicine with a major responsibility of developing a research and teaching program in the behavioral sciences. Then, in 1956 he went to Lexington, Kentucky, as professor of medical sociology and a member of the planning staff for the new Medical Center at the University of Kentucky.

His writings in the behavioral sciences are numerous. Major publications include the books, DRINKING IN COLLEGE with Selden Bacon in 1953 and MEDICAL CARE FOR SEAMEN in 1950. In addition, about 40 articles by Dr. Straus have appeared in the professional journals. He also serves ts associate editor for the Quarterly Journal of Studies on Alcohol.

emotional responses to situations of stress. Addiction to alcohol often appears in persons who have experienced relatively untroubled adult lives but whose problems can be associated with neurotic tendencies tracing back to childhood.

Alcohol for the alcoholic represents the most valued means of gratifying keenly felt basic needs for achieving pleasure or avoiding pain. Due to its pharmacological properties and its immediate effect on the central nervous system, alcohol in sufficient amounts provides a temporary illusion of success and well-being. It thus provides the alcoholic with a false solution for unbearable emotional stress. The end result of the action of alcohol on the central nervous system is increased tension. This is further magnified by a psychological reaction to such temporary relief. The alcoholic pattern thus becomes a vicious spiral. Each attempt at gaining relief through drinking eventually leads to greater stress and tension and a greater dependence on alcohol.

It should be emphasized that the deviations displayed by alcoholics in their behavioral responses to drinking and their over-all adjustment pattern show wide variations. Furthermore, these can frequently be distinguished only by a matter of degree from the reactions and behavior of non-alcoholics. The fact that about 94 percent of drinkers in this country do not experience the reactions which characterize the alcoholic suggests the relegation of alcohol itself to a secondary causal role.

It is now logical to consider what is being done to prevent this great tragedy. Fortunately, today we can say a good deal. Reference has already been made to the fact that some remarkable changes in attitudes and

BY narcotizing or dulling the higher brain centers which control judgment and conventional patterns of behavior, alcohol in moderate quantities releases inhibitions. Ordinarily shy people become sociable and garrulous. Instinctive behavior . . . which in the absence of alcohol is partially controlled by the higher brain centers, seems to dominate alcoholic behavior.

—from THE PROBLEM DRINKER
by Joseph Hirsch

AFTER any number of exhaustive tests (psychologists) have reached the conclusion that there is no such thing as an alcoholic type. Although the alcoholic develops a sort of superimposed personality that is easily recognizable, he may have belonged to any of the number of types. He may be an introvert, an extrovert, a sadist, a masochist; physically he may be athletic, pyknic, asthenic, dysplastic. Nothing has been learned in that direction. The one trait that potential alcoholics have in common is a maladjustment toward life.

—from THE OTHER SIDE OF THE BOTTLE
by Dwight Anderson

approaches toward alcoholism have taken place during the last fifteen years. The problem of alcohol and alcoholism are slowly but surely emerging from a veil of stigma, misconception, subjective and emotional opinion, and special interest pressure which have acted in the past to obscure facts in this field. These problems have become the objects of scientific investigation and are being approached with programs of research, education, and therapy geared to long range goals of prevention.

Research Needed

Since this is a problem area in which until recently even many of the simplest and most basic facts have not been known or understood, there has been *urgent need for many types of research effort.* Scientists at several of our universities have responded to these needs and have undertaken to investigate various aspects of the problem. At the Yale Center of Alcohol Studies for more than twenty years the disciplines of physiology, medicine, psychiatry, law, religion, economics, psychology, and sociology have been coordinated in a comprehensive research program.

Education and Prevention

Another prerequisite for the prevention and solution of problems of alcoholism is the *education of the general public.* To achieve realistic prevention, the use of alcoholic beverages must be understood as a custom deep-rooted in the cultural history of most people. The actual functions which alcohol plays in the human organism must become commonly known facts to replace many of the misconceived stereotyped beliefs which have prevailed. The progressive nature of alcoholism must be generally understood together with certain types of underlying causes and symptoms.

In the education of young people about alcohol, elements of inconsistency, coerciveness, and fear psychology must be eliminated. Undesirable behavior in this area by youth can sometimes be traced to revulsion against outmoded educational techniques, while intelligent and reasonable behavior can be expected to result from the straight-forward presentation of factual information.

The third prerequisite to an effective program for the prevention of alcoholism is *therapy for the alcoholic.* It has sometimes been suggested that perhaps too much emphasis is being placed on therapy and not enough on prevention. Of course, these two aims are in no way incompatible. Effective therapy is essential to prevention and is one of the most important elements in any approach to these problems.

Stigma Fading

No longer are the subjects of drinking and drunkenness completely dominated by ignorance, by stigma, or by the archaic doctrines of special interest factions. Although special interest groups continue to exert a certain amount of influence, the alcoholics themselves and the specialists who are working in the field now command the public's attention. A gradually developing informed public opinion no longer looks upon the excessive drinker as one who lacks will power, has sinned, or is worthless. Instead, more and more people are coming to realize that with proper research, educational and therapeutic approaches (1) rehabilitation of the alcoholic can be achieved, (2) the considerable loss which has been associated in the past with ineffective handling of the alcoholic can be eliminated, and (3) realistic programs of alcoholism can be inaugurated.

HOW JOHN Q. SEES ALKY AL

Reprinted from The Reporter, published by Florida Alcoholic Rehabilitation Program

PEOPLE are beginning to view the town drunk as a sick person rather than a lost sinner perversely pursuing his own destruction, a nationwide survey indicates.

So reports Elmo Roper and Associates, through the National Council on Alcoholism, Inc.

The alcoholic "is coming to be seen as a sick and suffering human being whose drive to liquor comes from powerful forces beyond his control, and who is in need of understanding and treatment rather than moral exhortation", Elmo Roper And Associates report in THE PUBLIC PULSE.

Further, the firm said, this new look at alcohol addiction shows up clearly in the answers a nationwide cross section gave to this survey question:

"If you knew someone who habitually drank so much that it affected his job and his relations with people, would you say that he is morally weak or would you say that he is sick?"

Thirty-five per cent of the persons interviewed said the subject is morally weak, 58 per cent said they believed such a person is sick. Seven per cent expressed no opinion.

The report continued, "That they (alcoholics) are truly victims of a sickness beyond their control is inevitably difficult to understand for those of us who drink—or not—at will."

"Alcoholics are often attractive and intelligent individuals who seem to act like anybody else—when sober. The difference is that their need for alcohol, and the escape it provides, is literally overwhelming."

The Roper report showed that residents of rural areas tended to view alcoholism more as a moral weakness than an illness.

In groups with less education the idea that alcoholism is a moral lapse still persists—among grammar school-educated people, 47 per cent called compulsive drinkers "morally weak," as opposed to only 26 percent of those with a college background, the report said.

Forty-four percent of people living in rural areas looked at the problem from a moralistic point of view, while the figure for the average city dweller was more than 10 percent lower.

Women, who records show are less likely to succumb to the illness than men, are more inclined than men to take a compassionate view of it.

But among both sexes a majority has come to see this problem in medical, rather than moral terms.

ALCOHOLISM and LONELINESS

Reprinted from PIONEER, published by the Pioneer AA Group, Washington State Penitentiary.

NO one but an alcoholic knows the price paid to alleviate loneliness.

It is probable a large number of alcoholics fall into their uncontrolled drinking habit through the factor of loneliness. It can very often be the feeling of aloneness that induces the idea into the mind that the bottle is a fine friend.

A friend that will nullify the downright despair. A friend that will even make everything take on a nice, rosy hue, leading one to believe happy days are here again. It can, seemingly, even help to find wonderful new friendships for one in the places he frequents to partake of the cheer of the bottle. To a person who always thought of himself as being misunderstood and alone in life, this can be a wonderful boon. So it has been with me.

In the ranks of alcoholism may be found many introverted, predominantly shy people. These people, as a rule, are quite sensitive, taking to heart any of the small slights and misunderstandings that may arise in the course of a day. These are very likely to prey heavily upon their minds, accumulating and bringing about eventually a feeling of almost complete inadequacy. A psychologist would call this an acute inferiority complex. They may come to doubt their own abilities as regards the performance of even the simplest of their duties in life. They may come to shy away from any new contacts with other people in the course of their existence.

Thus they shy away from others who are strange to them. They make very few, if any, new friends. Their acquaintances and friends, unable to understand this, often increase isolation and strangeness. This, in turn, prompts avoiding contact with them. This self-imposed isolation increases upon itself, becoming ever greater. The person himself may completely fail to understand the reason others drift away from him, thinking oft-times it is the fault of these others, and resenting highly their actions.

Near Desperation

Eventually, a feeling akin to desperation may come to a person such as this. He feels completely alone. He thinks himself friendless and misunderstood. He wanders through his everyday existence, hoping on hope he will find an honest friend who will solve his problems and set everything aright in his little world again. But due to his reclusion, his entire demeanor will often tend to repel others| He keeps hoping, however. That is the paradox of the hopeless. They live on hope. So he

(Continued on page 20)

The lonely alcoholic hopes forever, but then it is the paradox of the hopeless to live on hope.

BY KENNY C.

keeps seeking yet never finding anyone who can live up to the right specifications he places upon friendship. Few, if any, would be willing. Even loved ones fail to fill the bill.

A person who has come to follow in this general line is a setup and a pushover for alcoholism. So it was with me. Somewhere, sometime, I became introduced to the cup that cheers. The ultimate result can be immediate or it may develop gradually. The first thing this individual will notice is a very pleasant feeling of relaxation. He feels relieved of some of his tension, the monumental problems that have been plaguing him seem somehow less pressing. He tries another. The alcohol circulates to his brain, anesthetizing his centers of fine judgment. His inhibitions are dulled and then leave him.

A New Personality

This is wonderful. For the first time he can say the things to others he has always wanted to say. The personality he has always considered superior in his heart seems to shine forth. He believes he is illuminating the room with flowing benevolence. Suddenly he has found a host of new friends. His problems are solved, or so he thinks.

As time passes the embryo alcoholic will call more and more often upon this magic he has found which seemingly solves his problems. His newly found friends are there. He hurries through his working hours, impatient for the time when he can again join them and lose his tensions and problems of the day in the bottle and fellowship of the companions he has found. Here at last he is sure are understanding people who appreciate his fine abilities. No one else has ever done this before in his memory. How could anything like this be harmful?

His family and friends of predrinking days may come to tell him this is wrong. They may say his drinking is becoming a serious problem, one he should part from. He will probably consider they completely lack understanding of him and his problems. Should they persist in criticizing his drinking habits and his new-found friends, they will simply drive him to seeking condolence more and more frequently through this new medium.

Eventually, however, he may awake to the idea something is wrong. His job is becoming shaky or he has been losing jobs frequently. His family life is becoming untenable. As this continues with increasingly dire results, he may even come to realize it is his drinking that is to blame for this. So realizing, he makes resolutions. He promises his family and employer that he is going to quit drinking.

He even tries. But there is something that keeps drawing him back. The time he spends sober is often completely unhappy. He knows of no other way to find relief for his tensions and unhappiness than his old companion, the bottle. He finds he is unable to stay away from it for any length of time. He has nothing to replace this in his life. Without alcohol his life is empty. He is an alcoholic.

This could seem to be an extreme and dire description of this particular phase of alcoholism. Remember, this is the way I see it. This may be due to the fact persons so afflicted are docile. When sober they do not show their inner thoughts and feelings on the surface. They tend to hide their true feelings from everyone, seeming often quite isolated in relations with others.

For unfortunates such as these—

myself included—AA is the greatest hope for a life containing happiness and the benefits others enjoy in their lives. The person who enters into and accepts wholeheartedly and honestly the AA program, will find, I believe, the answer to practically all of the problems that have been dogging him. He will find wholesome companionship with others who have similar problems and are sympathetic to his needs and desires. He will find he can express himself to people who will understand and listen avidly. There will be enlightening activities for him. He will learn understanding of others as well as of his own needs. He can develop his spiritual life, finding calm and strength of purpose through this. Through this sincere participation he will arrest his alcoholism. Even more important will be the alleviation and elimination of the personality problems that were the initial cause of his alcoholism.

Any alcoholic, who arrives at a sincere desire to find a better way of life and who can be scrupulously honest with himself, can find this through active participation in the AA program. It has worked for many who thought themselves hopeless, doomed to a drunkard's grave.

The most wonderful thing about AA, able seemingly to accomplish miracles with hopeless lives, is that it is open to anyone who needs it. There are no dues or stringent rules, no one is qualified to look down upon the next person. For each successful member of AA has been there. He has hit a personal bottom and risen again through AA.

Anyone who yet suffers is welcome in the program. More than this, he is needed, for it is the new arrival and the many yet in need, that keep refreshing and swelling the ranks and effectiveness of the AA brotherhood.

Hobbies

HOME-STYLE THERAPY

Whether its photography, sewing, or fishing, throw off your cloak of worries and adopt a new interest in life. Open your eyes and look at the world around you. You'll like it.

BY CLAIRE CHENEY

IN this world of ours where tension and pressures are constantly threatening our peace of mind, there is a need for us to "escape from it all", to dissociate ourselves from the worries that plague us from time to time.

Alcoholics particularly have found that their need to escape is so great as to send them again and again to the bottle, even when they realize that with every drink they become more and more out of touch with reality. Alcohol provides them with what they want, an inability to feel.

We all need to escape. People who attend four and five movies a week unless for professional reasons are finding terrific diversion in watching Clark Gable make a pass at Doris Day, or Gary Cooper riding the prairie, looking for the gang of rustlers who robbed him of his herd. Those people who cannot sit down for a minute without picking up a book and who consume five or six books a week are in a sense living in another world, a world more pleasant than the one they find themselves living in.

Reading and theatre-going are enjoyable and stimulating; they provide recreation and education and are as natural and normal as any diversions our society has. But carried to the extreme, it becomes another matter.

To have a cocktail before dinner is also a mild form of escape, since the alcohol acts on the brain as an anesthetic, but to drink five or six cocktails before and after dinner every night in the week is not normal and it means that the drinker is looking for more than a mild diversion or escape from whatever it is that is bothering him. He wants com-

plete anesthetization.

Alcoholic treatment centers have long recognized the human need for escape and as a part of their treatment programs, have instigated occupational therapy classes where patients can learn rug weaving, wood carving, ceramics, painting, etc. Here the patient can express himself without reservation or fear of exposure. Occupational therapy provides an excellent source of insight both to the therapist and the patient.

Aside, though, from the human need to escape there is the urge to create—to do or make something that no one else can duplicate—to make a mark on the world that is wholly theirs. Who can duplicate Van Gogh's paintings or Beethoven's music or Charles Dickens' characters? No one. There are many imitations, but nothing anyone has ever painted, composed, or written can duplicate the original creation.

The desire to create is in all of us, beginning with a desire for children, to propagate one's own kind. Creation is apparent in the simplest cake that Mom bakes, the dress that Sister made in Home Ec. class, the table that Pop made for the living room. No one else could have done it exactly as they did it. They created and what they created is ultimately theirs. They alone received the great satisfaction that comes with taking a few raw materials and out of them making something of beauty.

Hobbyists have long since discovered the relaxation and gratification that comes with the combination of escape plus creation. Perhaps you know a man on your street who putters around the yard all the time. Perhaps he doesn't accomplish much

compared to the number of hours he spends out there, but have you noticed the look on his face when he goes out to look at his plants each day, seeing how much they've grown within the past 24 hours? The look is comparable to the look fathers give their new born babes as they lie in their cribs. They (with the help of Mother Nature) have created a living thing. Here again is creation and along with it, great satisfaction for the creator.

We all might well adopt a little of this occupational therapy at home. We've heard wives say that after an argument with their husbands, they can really rush in and give their houses a thorough cleaning. What better way is there to work off anger than down on your knees scrubbing the kitchen floor or giving the furniture a thorough waxing and polishing? It's certainly a more creative way to get rid of hostility than throwing a temper tantrum and in the long run more satisfying, too, to all concerned.

A Type of Therapy

Another form of occupational therapy and one more lasting and rewarding than sporadic housecleaning is to adopt a hobby. Have you always been interested in photography but haven't had time, you say, to develop your interest? If time is what you're waiting for, you'll never have enough of it. Besides, haven't you heard that you have all the time there is? The question is whether or not you're using your time wisely.

If you feel you can't afford an expensive camera right away, rent or borrow a cheaper one and start today on your hobby of photography. Not only will it give you creative satisfaction, but you'll be the delight of your family and friends. If you become good enough, you might even find it a way to make a little side money since there probably hasn't been a club or organization invented that doesn't want to to have a picture taken of their members at some time or another.

If you have a mechanical bent but are dismayed at the complicated structures that go into making today's automobiles (and who wouldn't be?), try tinkering with something else. A hi-fi set is easy for someone mechanically inclined and will be a grand addition to your household. Think of the hours of pleasure that lie ahead in listening to your favorite records, with each note realizing that you alone made the instrument that reproduces that glorious sound.

Sewing is a wonderful hobby for women and think of the money you'll save! And what a thrill it is to put on a dress in the morning that you alone put together. What if the hemline sags a little in one place, you made it, didn't you? Soon with time and experience, you'll learn how to avoid those little imperfections that plague you at first until you become the envy of the neighborhood at your skill in making and maybe even designing your own clothes.

Perhaps in your early school years, you discovered you had a talent for drawing or molding clay or perhaps you acquired an aptitude for being high scorer at every school basketball game. You've always meant to do something with that talent of yours but what with earning a living, raising children and trying to keep your head above water, you've neglected doing something about it. Now's the time to bring that talent out into the open. Start going down to the gym for exercise if you enjoy sports. Or get out that drawing pad when you have a few minutes and sketch your child sleeping or playing. You might find the door opening to a whole new

life as a professional artist.

The point is to excel at something, no matter how trivial it may seem. Your Aunt Mary made the best pound cake you ever tasted. That was her hobby, you might say and she excelled at it. When she saw the look on your face as you tasted the first morsel of cake right out of the oven, it was worth all that went into creating it. Suppose your Uncle John's ghost stories made you shiver and tremble as a child long after you went to bed. No one could tell stories like Uncle John. That was *his* hobby and you loved him for it.

Need To Excel

We all want to excel, to be better than the next person. But we can't excel in everything. We're just not made that way; there's always somebody just a little bit better than we are. But we can excel in something. Find out what you enjoy, what gives you the greatest pleasure and by golly sit down and make yourself go to it. You won't excel at first, but if you keep at it, you'll find that what you're creating cannot be matched to anything else in the world. It's yours! And when you think you've done your best, keep on working at it. Creating with the very best in you puts you a little closer with your Creator.

It is said that alcoholics are among the most sensitive people in the world and it is this sensitivity which makes alcohol so attractive for them. It dulls the hurt they feel inside. But if an alcoholic could, just for a little while, put the bottle away, he'd discover so many things about this world of ours. And this is true not only of alcoholics. It applies to everyone who has shut himself off from living.

Is there anything more beautiful than the aurora borealis on a star-lit night, anything more comforting than hearing a hoot owl or a bob-white in the night as you are half-asleep? What about the smell of the air just before and after a heavy rain? It's so heavy you can almost touch it. Isn't the sound of the ocean a happy sound?

These sensations come from an awareness of things around us. Unfortunately some people are not aware. They see and hear, as if by rote. Think of what they're missing!

We are all endowed with the gift to hear, smell, taste, see and feel. But often in our narrow, restricted lives we hear nothing but the tinkle of money, the baby crying, the wife nagging, the boss scolding. We have truly lost our senses.

There is so much more to living than the office, the bank balance, the commuter train, the frowns and tensions of people who walk by on the street. There are flowers from your own garden, a special pie you baked for Sunday dinner, the walk in the woods, the singing of the birds, the different sounds sea shells make.

Take Time Off

Take a little time off from your worries. Become aware of what's around you, participate in things, become a part of the world. Escape from your pressures and headaches to a part of your life much more attractive—the awareness and interest in things you had as a child but have since lost. Choose a hobby and work at it, because if you don't put your heart and soul into it, it won't mean a thing to you. Take pride in your accomplishments and watch your new attitudes drift over into other parts of your life. Try it for just 30 days, if you have doubts, and see if they don't become the first of some of the most fulfilling days of your life.

WHAT ABOUT ANTABUSE?

Reprinted by permission of the New Hampshire Bulletin on Alcoholism, published by N. H. Division on Alcoholism

THIS report is a brief summary of a survey recently completed by the New Hampshire Division on Alcoholism. Although we do not advocate Antabuse as a cure-all, we have for some time used Antabuse for selected alcoholics under the medical supervision of their family physician. This report deals only with those alcoholics who came to us for help; thus the conclusions obviously cannot apply to all alcoholics.

While we recognize that certain personalities and certain types of environmental situations exist which would make the use of Antabuse either more or less advantageous to the individual alcoholic, we thought a report was needed at this time on some of our experience with Antabuse without necessarily becoming involved in these other areas. We have long felt that Antabuse was an adjunctive, supportive type of treatment, which acted as a sort of external control over any wish the alcoholic might have to resume drinking; and that its primary purpose was in helping certain alcoholics maintain sobriety during this extremely difficult period of adjustment from a life of drinking to a life of abstinence. We have also felt that it was necessary during this period of enforced abstinence for the alcoholic to seek help for his difficulties, since the external threat implied through the use of Antabuse alone would not provide sufficient, long lasting, motivation for continual sobriety. Eventually, through other forms of assistance, these alcoholics would rebuild their lives around abstinence, and develop from within themselves the strength to maintain their objective.

With this reasoning in mind, we were interested in determining how long our patients remained on this drug. We felt the alcoholic who continued Antabuse indefinitely depended upon Antabuse as his primary means of maintaining sobriety; whereas if he took Antabuse for a short period of time, he was in fact utilizing the drug for emergency assistance as an "external control" which would soon "wear out". Further, we wondered when this would lessen to the extent that he would discontinue the Antabuse. Did patients stop Antabuse shortly after they were discharged from our hospital, or did they continue for an appreciable period? Also, what factors seemed to affect the length of time they were on Antabuse?

Our survey disclosed a rather interesting trend. We found that 95% of the patients placed on Antabuse stopped within a four-month period. Of course, this did not mean they resumed drinking since many of them had found other ways of being helped and evidently no longer felt they needed the control of Antabuse. We also found that of those who took Antabuse and refused any other forms of help 22% continued on Antabuse beyond one month, while 50% of the group who sought additional treatment remained on Antabuse beyond the first month.

From our figures it appeared that

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LET'S MAKE RELIGION A promise... NOT A threat

Reprinted by permission from the April, 1958 issue of PASTORAL PSYCHOLOGY.

BY REV. CLARENCE REIDENBACH

Religion can help the alcoholic find the great antidote of fear—faith.

I do not suppose that there are many alcoholics in most congregations, but there ought to be. They ought to be able to come straight to us, and we ought to be able to help them. We should know what to do with the occasional problem of alcoholism that may bob up in one of our churches, but beyond that we should be ready to understand any one of the millions of alcoholics that suffer in our land. It will be a humanitarian work, and it will be a spiritual work, for alcoholism is generally a symptom of an emotional disease festering within the spirit.

Can the minister have a role in helping to solve the problem of the alcoholic? It might seem that he could not; of recent years, at any rate, ministers have not had a chance to do much with alcoholics. These people have not been in the habit of coming to us. To begin with, the alcoholic does not trust any non-alcoholic to understand, and that seems to go double for the minister. Alcoholics feel that ministers will take a critical and moralistic attitude toward them, or that, if they are sympathetic, they will simply not know what to do. But if they find a minister with a sympathetic objectivity and a non-judging attitude, they flock to him and his church. Their gratitude will be enthusiastic and touching.

We ministers, when we are real ministers, are in a position to be especially effective with the problem of alcoholism. The attitude and per-

sonality of the counselor is more than half in winning the battle, and ministers by definition have a favorable atttitude. We are trained to care. We believe that any one is a child of God and that all things are possible with God. All people are worth saving and can be saved. One alcoholic woman put her feelings to her minister in these words: "You have been a special help to me. You are not an alcoholic, and yet you do not condemn me."

Religion can play an important role in the healing of alcoholics. A sad fact is that religion has often unwittingly played a part in aggravating the problem: It has deepened the alcoholic's guilt feeling. Under the guilt feeling the alcoholic has come to feel lost and desperate. Many of these people are products of Sunday School and church. A few years ago I asked a skid row group in Oakland how many of them had gone to Sunday School; every hand went up. I tried the same question on a skid row group in San Francisco, and about ninety percent raised their hands. We ministers can certainly help those who suffer from their impressions of religion. Among other things, we can make religion a promise rather than a threat, and we can make it seem more natural and to the point.

Faith And Fear

Alcoholics are full of fears and inferiority feelings. We can help them find a faith. Faith is the great antidote of fear. Any one who has read far in psychiatric literature will have come upon the emphasis of faith, and what force is better suited to provide faith than religion? Alcoholics often say that their number one problem is resentment. Like other neurotics, they are self-centered; they often have big-shot complexes. The antidote for all this is love. The psychiatric literature is even more full of the emphasis on love, getting out of the egocentric shell, than on faith. Religion makes a basic point of love. Alcoholics, like other people, have guilt feelings, and being more sensitive they have them in extreme form. They feel bitter remorse over their drinking and over a lot of other things. The love and forgiveness of God are great thoughts to a guilt-laden mind. Alcoholics Anonymous lays great stress upon the spiritual part of its program; its twelve steps are all moral and spiritual, in fact, broadly religious. We in religion can help to interpret the AA program.

We ministers can and should inform ourselves on alcoholism. We can read on the subject. We can get into touch with Alcoholics Anonymous. We can help our own people when they are in trouble. We can help the alcoholics who will begin to come to us when they find out about our interest. We can teach the wives and husbands of alcoholics. We can help to inform the public. We can do fifth step work in AA, which is to assist in the moral and personal inventory; in other words, to hear confession or to assist in catharsis. If we are trusted enough we may even be called upon to do twelfth step work, which is to carry the message to alcoholics when they ask for help.

Of course, we want to know how to go about it, and perhaps more important we want to know how not to go at it. Here are some don'ts for counselors, for wives and husbands, for any one who attempts to help. Do not preach or lecture. Do not moralize. Do not be ministerially professional. Do not make the counselee feel ashamed or guilty. Do not attempt to work on a basis of logic or reason; the alcoholic knows how

silly and damaging his behavior is. Do not pour his liquor down the sink or try to take it away from him. Do not try to police him. The reason for these don'ts is that none of them will work; they will only make the situation worse. On the other hand, the counselor cannot act as an anxious nurse-maid. He cannot be forever protecting the drunk from the results of his drinking, although he sometimes will. You cannot forever run because some one is in jail or threatens suicide. You cannot do psychotherapy with a person when he is drunk. The counselor's value is not in sobering up drunks, but in talking with people who really want help when they are sober.

The counselor's attitude is determinative. If you do not have a favorable attitude, you will never see anybody more than once. The best words I can think of for the attitude is objective friendliness. You have to be warmly receptive without being a sentimental soft touch. You will have to be non-shockable. It is important that you be easy to talk to. You will have to become acquainted with the nature of the alcoholic. Why has he done this thing? Why this compulsive behavior? What are his emotional problems? There are a variety of them. They cannot be listed within the limits of a short article, but be sure to find out about his fears, inferiorities, resentments, and guilt feelings. Find out about his early life in his family relationships.

Elation Dangerous

There is one feeling that surprised me: I thought that drinking came from worry, etc., but a number of alcoholics have told me that their most dangerous time was when they felt good; they felt high and wanted to perpetuate it. Some of these people seem to be mystics at heart, and the only way they have had to get the mystic feeling of exaltation and illumination was through alcohol.

There is a specific problem that should be emphasized. When the alcoholic tries to go off alcohol, he often has acute discomfort and pain. His nerves jangle, he feels that his chest is going to cave in or explode, his stomach goes sour, his intestines burn, he feels depressed, etc. I have heard it described many times, and my impression is that it must be pure hell. The ghastly part of it is that two drinks will relieve all that discomfort immediately. Now, we have to find ways to keep those rugged times from appearing as much as we can, and we have to find substitute means for alleviating the discomfort so that the sufferer is not driven to alcohol. Punching a punching bag will drain off resentments. One man I know resorts to his music records. In dealing with underlying emotional problems we shall need to know something of the psychiatric techniques that are used in finding out what is the matter with people even when they do not know themselves. When we have found out what the problems are, then we have to lighten the load and make the job easier and more possible.

One can learn a good deal about alcoholism by reading. Reading can provide information, even though the information is made more vidid by experience. Marty Mann's book, *Primer on Alcoholism,* is important; it covers the whole field. The so-called "big book" of AA, called simply *Alcoholics Anonymous,* is a must, I think. It not only helps to understand alcoholism; it is as good a book on practical religion as one could wish to read. The best single thing that one could do in his own learning would be to get into contact with Alcoholics Anonymous. My own first

contact came through hearing two members present the story of their organization to a medical school class. Literature was given to me. The twelve steps sounded like a religion. I preached a sermon on it. AA heard about it, and turned out in droves. I became a speaker. I saw alcoholics. In 1945 I was made an honorary member.

Now not every one has a medical school in his front door-yard or the opportunity to audit its classes. But in these days AA is likely to be not far away. Go to an open meeting. Get acquainted. Let it be known that this movement has your admiration and support. Get in touch with the AA secretary, if there is one. Get the AA spirit and preach on it. Ask questions. Be willing to help AA, both in speaking at open meetings and in seeing individuals who will want to talk about their problems. If there is no AA near at hand, find out all you can about it, absorb its spirit, and use it the first chance you get.

A Friend of Alcoholics

If the alcoholics accept you as a friend, you will soon have plenty to do. It will be hard work, and lots of it. But the work does pay off. You will have the feeling that you are really doing something. You will have a lot of new friends. They will teach you about alcoholism, and this will make you a better counselor in general; it will give you an education in psychiatry, for the emotional make-up of the alcoholic is similar to that of many other neurotics. Alcoholism, I think, is generally a symptom of neurosis; the alcoholic is one kind of neurotic. (Don't shy too much at the word "neurotic"; it just means pretty bad nervousness, and all of us are neurotic to some degree.) Your new friends will help to make you a better human being. Quite a few of them will come to your church, and they make very good church members. They are sensitive, emotional, even artistic; they have had a conversion, and they feel their religion. Incidentally, my contact with AA has renewed my faith. I have seen religion in action, pretty much as in the book of Acts, with confession, conversion, faith, devotion, and even miracles.

What About Antabuse?

(Continued from page 26)

the continuation of Antabuse is dependent to quite an extent upon the fact that the patient feels other people are interested in him, and therefore, he is more willing to show his determination to be co-operative by remaining on Antabuse. But even these patients, within a relatively short period of time, cease Antabuse.

On the basis of our own evidence we feel that Antabuse at best is only a temporary safeguard. Its usefulness in certain situations, however, is well recognized. We would suggest, therefore, that patients prescribed Antabuse be given the opportunity to talk things over with someone interested in their welfare for the first three or four months. In this way the alcoholic on Antabuse would be more likely to continue this drug beyond the first month. Secondly, and most importantly, we feel it essential that help be extended to the alcoholic on Antabuse during the short period of time he takes the medicine and that he be encouraged to participate in those activities or organizations which will help to insure his maintaining sobriety once the external control of Antabuse is removed.

Problems are present in everyone's life. This is . . .

THE BASIC REALITY

BY ROBERT M. FINK, PH.D.

ONE of the attributes of mental health is the ability to recognize and accept the realities of life—most of the time. It is comparatively easy to recognize and accept realities which are pleasant; it is often exceedingly difficult to recognize and to accept realities which are unpleasant.

Perhaps the basic reality is that life is a constant series of problems. One of the normal characteristics of life is that every action requires a choice—a choice between two or more ways of acting—or between acting and not acting. Every choice, probably, has an element of conflict. That is, each of the alternatives has both desirable and undesirable results. And no matter which choice a man makes he must take some pain along with some pleasure or satisfaction. This is what often makes choices difficult—it is hard to weigh and decide which alternative will give the most pleasure and the least pain. When the results of the alternatives are about equal or when either will result in considerable pain, man's mind often is in conflict —it is unable to choose a course of action and it is exceedingly uncomfortable. We might say it is not at peace with itself.

These conflicts over choice are what we commonly call problems. Some problems are easy ones; some are very difficult; most range in between. But they are *always* present in human existence. *Every* human being has problems; *every* human being has difficult, even insurmountable problems. Problems are a fundamental characteristic in human *life*.

THIS IS THE BASIC REALITY. This is the reality which we often think of as a sort of disease of man, as a defect in his nature. We seek a panacea which will eliminate all human problems. In this thought and in this search we ignore the basic reality—IT IS THE NATURE OF HUMAN LIFE THAT IT BE A CONSTANT SERIES OF PROBLEMS. And about fifty percent of these problems, by chance, would be accompanied by some pain or discomfort. Of course, being intelligent we are able to reduce the incidence of pain by choice of action.

Thousands of people have sought through superstitions, such as astrology, to find an answer to all problems. Others have sought through education to find all the answers. More recently psychology and psychiatry have been looked to as the answer and "mental health" has become regarded as a channel for washing away all human problems. Education and the areas of psychology and psychiatry together probably cannot change the basic characteristics of human life. They *can* help us to understand these characteristics better. *They can help us to recognize the reality and normality of human problems;* they can help us to accept this reality as something which cannot be changed; they can help us to be reasonably comfortable with these realities.

Books of Interest

BEYOND MY WORTH

BY LILLIAN ROTH

Frederick Fell, Inc.
New York

317 pp. $3.95

THE story of a gallant woman fighting to keep her hard-won sobriety is told by Lillian Roth in her book "Beyond My Worth". Readers of her first book, "I'll Cry Tomorrow" will remember Miss Roth's struggle with the bottle, her frustrated personal and private life, and finally her victory over alcoholism. Perhaps many readers thought that once Miss Roth had achieved her sobriety, her problems would be solved.

Unfortunately this was not true, as Miss Roth tells us in this continuation of her life story. Since she chose to return to night club singing because she felt she must face squarely what had formerly intimidated her, she was constantly battling a threatened drinking bout, on some occasions coming so close as to actually pour the liquid into a glass, until at the last minute an inner strength saved her.

Many might criticize Miss Roth for returning to public life, thinking that she was only asking for trouble. But this woman felt she had no choice. She had to prove to herself that she could do it. The brief period in which she and her husband, Burt, also a recovered alcoholic, had been in seclusion had made them both miserable. "Life is a struggle", she says, "and to stop struggling is to stop living. But that struggle is not for money alone, but to create, to realize the best within us. In this way we draw close to God."

Many obstacles have been placed in her way. Agents and theatre owners called her a "lush", said they couldn't trust her. Every headache or sleepless night was attributed by her "friends" to the bottle. Any slight illness, such as a mere cold, was called a hangover. Even today there are untrue rumors that she has "slipped."

To make matters worse, she began having spells of blindness which even now she still experiences. But her faith in God and in the innate goodness of people and her readiness to help those who need her have given material and spiritual benefits which she considers beyond her worth.

Her Answer

Miss Roth found her answer for continued sobriety very simply. When periods of depression came upon her, she found that by thinking of others not so fortunate as she, others whom she admired, such as the girl with multiple sclerosis, the war-shocked soldiers she entertained in hospitals, the life prisoner with whom she corresponded, she was able to forget her own troubles.

Active alcoholics will receive inspiration from this book and those who have recovered will sympathize with Miss Roth and perhaps receive something from her that will make the 24-hour day a little shorter.

Claire Cheney

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-Patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Display—Primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

JULY-AUGUST, 1958

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Doctor's Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, an occupational therapist, and ten attendants.

The Voluntary Patient

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Visiting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 10 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Educational Director

S. K. PROCTOR
Executive Director

DONALD MACDONALD, M.D.
Clinical Director

ROBERTA LYTLE, R.N., M.S.Sc.
Psychiatric Social Work Consultant

INVENTORY

VOLUME VIII NUMBER 2

JULY-AUGUST, 1958

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices Old Health Bldg., Raleigh, North Carolina.

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UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

AT each of the last three sessions of Congress, legislation has been introduced that would require the Department of Health, Education and Welfare and particularly the U. S. Public Health Service and its National Institute of Mental Health to provide special service in the field of alcoholism. U. S. Public Health Service and the National Institute of Mental Health have not looked with favor upon such legislation and have contributed to its failure to pass.

Sentiment in Congress and from State Government and other pressure groups appears to be mounting and it seems probable that the time is not far distant when Congress will pass some sort of special legislation aimed at alcoholism.

In April, the National Institute of Mental Health of the Public Health Service invited the Executive Committee of the North American Association of Alcoholism Programs to meet with representatives of the National Institutes of Health to discuss the needs and the appropriateness of federal legislation.

The North American Association of Alcoholism Programs is an organization of state and territorial government alcoholism programs, of which the North Carolina Alcoholic Rehabilitation Program is a charter member. Your ARP State Director has been on the Executive Committee of this organization either as an officer or as the single selected individual member-at-large for six of the eight years our organization has been a member.

The National Institutes of Health are not warmly disposed to categorical legislation setting up separately identified or special funds for alcoholism. They would prefer using a portion of funds in their regular budget to give assistance to alcoholism research and to contribute financially toward the training of professional workers in the field of alcoholism. Representatives of the National Institutes of Health recognize the growing and increasing interest in Congress for special legislation in regard to alcoholism and that the National Institute of Health will be put in the position of administering a program with which they may be not wholly in sympathy. The legislation that has been presented previously in Congress has been ill prepared and has not been supported by the North American Association of Alcoholism Programs or its membership. In other words, the U. S. Public Health Service and the North American Association of Alcoholism Programs and its membership have opposed previous legislation presented in Congress because in our collective opinions the requested legislation was not

(Continued on page 29)

News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

ASHEVILLE: The Southeastern Convention of Alcoholics Anonymous will be held in Asheville, North Carolina, August 22-24.

SAN FRANCISCO: Mt. Zion Hospital will shortly be the only general hospital in San Francisco to admit on the same basis as other ill persons those suffering from acute alcoholism. The medical staff approved the move following a year of successful experimentation in care for alcoholics.

LONDON, ENGLAND: A recent TV series on Alcoholics Anonymous has been reported successful. The programs, carried each Sunday following the 11 o'clock news, stimulated approximately 500 telephone calls and letters asking for help and information.

WASHINGTON: Tucked away in a multi-million dollar appropriation now moving through the U. S. Senate is a $700,000 item earmarked for alcoholism research to be conducted under supervision of the National Institute of Mental Health. Although $700,000 is not a lot of money by comparison with outlays for other medical research, it is far more than has ever been invested before in scientific studies of the physicial, psychological and environmental factors causing alcoholism.

S. KINION PROCTOR

With profound regret, we record the passing of our Executive Director and good friend, S. Kinion Proctor. He died in Duke Hospital on August 12 after a critical illness of two weeks. Mr. Proctor had been Director of the N.C.A.R.P. since its inception in 1949, and was a nationally-known figure in the field of alcoholism education and rehabilitation. His loss will be keenly felt not only by those who enjoyed a personal relationship with him, but by those countless fellow workers who labor in the advancement of the cause to which he was so devoted. On behalf of those who knew Mr. Proctor, both personally and through his professional reputation, we express deepest sympathy to his wife and daughters, his mother, his brother and to the other members of the family.

An editorial in tribute to Mr. Proctor will appear in the next issue of this magazine.

The Editor's Page

HOPE FOR THE ALCOHOLIC

MUCH of the current NCARP public education is based on the theme—*There is Hope for the Alcoholic.* Our symbol, The Star Of Hope, was conceived with this in mind. Our television spot announcement series, now carried as a public service by all major North Carolina TV stations, conveys this hopeful message.

Without indulging in irresponsible optimism, we think alcoholism education is justified in adopting a slightly more hopeful, more optimistic tone than in the past. For a long time we have been trying to evoke public understanding for the alcoholic by dramatizing the tragic aspects of the illness. And make no mistake about it, alcoholism *is* a tragic illness. Directly and indirectly it produces as much suffering and heartbreak as any other social malady afflicting us in the modern age. It is important that the public understand and to some extent sympathize with the sufferers. This is the first step toward arousing the public to action.

But we cannot stop here. In our zeal to produce public feeling, we must be cautious lest we evoke nothing more than maudlin pity. And pity, particularly for those to whom it is directed, is a malignant, static sentiment. If we have only pity to offer the alcoholic, we may as well offer him nothing. Through sentimental "sympathizing" we only encourage him in his self-pity, an emotion with which he is already overstocked.

May we suggest that it is time to begin stressing the other side of the educational story about alcoholism. Let us emphasize that in spite of its tragic side, alcoholism is not by any means a hopeless condition. It is time, figuratively speaking, to stop standing over the alcoholic, wringing our hands and saying to one another, "Isn't it a pity about poor Joe . . . an alcoholic . . . such a shame!" Let us begin to say to him, instead, "Joe, we understand you're a sick man and we're sorry. Now let's see what can be done to help you get well."

There are a number of developments which prove a more hopeful approach to be well-founded. Let us mention only a few.

First, there are signs of *enlightened public opinion* toward this problem. The last issue of INVENTORY carried a report of a Roper Poll, showing that nearly 60 per cent of the people inter-

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VOL. VIII, NO. 2 INVENTORY JULY-AUGUST, 1958

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

ALCOHOLISM

a psychiatric point of view

BY ALFRED AGRIN, M.D.

Reprinted from GEORGIA LOOKS AT ALCOHOLISM, published by the Georgia Commission on Alcoholism, Atlanta.

An "inside" look at the alcoholic

plus new thoughts about old ideas.

THROUGHOUT man's history, alcoholism has been recognized as a severe disturbance of human behavior, and many attempts have been made to try to define it. These attempts have ranged all the way from a concept of "there must be the devil in him," which carries the idea of sinfulness, to the more modern ideas. The latter are either that alcoholism is a disease entity in itself and represents some kind of a disturbance in the inherited physical makeup of the individual, or that it is merely the outward expression or symptom of an underlying disturbance in the person's personality, which brings the idea of its being a form of mental illness. It is because of this last point of view that psychiatry has become interested in alcoholism and alcoholics. (Because psychiatrists are interested in the personality of people and the disturbances in the personality which result in certain forms of behavior which in turn result in certain difficulties to the individual concerned and to society in general.) My definition of alcoholism, I believe, is rather simple and it goes much as the following:

1. The alcoholic is a person for whom the desire for the intake of alcohol in some form or other becomes stronger, more or less frequently, and more or less regularly than even the most basic of human instincts. These basic human in-

stincts are commonly supposed to be sex, hunger, and self-preservation.

2. The alcoholic, to me, is the person who *"must"* have a drink before he can do the next step in living, whether this step is eating, working, dancing or paying one's bills. This does not mean that the alcoholic, from time to time, does not pay his bills or eat or have sexual and social relations, but it does mean that frequently he needs and "must have" some alcoholic beverage within him in order to feel comfortable in doing so. Is it any wonder then that the alcoholic who from time to time can shelve rather basic human needs and instincts, can so frequently shelve responsibility which is not at all a basic human instinct, but is a learned and often resented thing?

Terms Defined

The alcoholic is often called "a childish and immature person." Now, while I have no objection to the use of those terms, I do feel that in order for them to become useful and meaningful to the individual involved, they should be carefully defined. In order to understand the use of such terms as "childish and immature" one must have some understanding of just what is childish about the alcoholic. There are several mechanisms which one can reasonably call childish. They are as follows:

1. *The child has a need for immediate escape from discomfort.*

A child does not easily tolerate either mental or physical discomfort and tries very hard to get away from it. Not only does he try hard to get away from it, but to a child mental and physical discomfort have almost destructive feelings connected to it. The child literally feels that if he does not get away from this severe discomfort life really is intolerable. When a child gets a cut he wants a band aid on it immediately.

2. *The child has a need for immediate satisfaction of his desires.*

When a child is hungry he wants to eat *now,* when thirsty he must have something to drink right away. When a child wants attention it does not matter whether the adults are busy or not, he wants attention *now,* demands it, and finds ways to get it. If a child cannot get immediate attention through being "good", he gets it by being "bad".

Both of these childish needs we expect to gradually diminish as a child grows up. However, with some people, and the alcoholic is perhaps the most obvious example, they do not diminish. If anything, they increase. Of course, the alcoholic is not alone in this way, many non-alcoholics also have intense needs to escape from physical and mental pain and discomfort and intense need to have their desires satisfied immediately. However, the alcoholic is a most obvious example since alcohol serves as a means of diminishing the sensation of pain, both physical and psychic, and also alcohol can serve as a quite reasonable substitute for other desires which seem to require immediate satisfaction.

3. *Perhaps one of the most striking things about children and immature adults is the need to control one's environment, particularly to control the feelings of those surrounding him.*

The child tries intensely to make people around him happy when he is happy, or sad when he is sad, and he is quite uncomfortable when he finds that he alone is enjoying himself or he alone is feeling badly. As a matter of fact, only extremely disturbed children can completely enjoy themselves by themselves for long periods of time, or, be completely un-

happy for a long time without calling attention to their unhappiness.

No one is more remorseful than the alcoholic when he is recovering from a drunk, yet when drunk he is so demanding that others cannot enjoy themselves with him. Thus, when recovering from a bender the alcoholic is quite upset if no one else feels as badly about himself as he does, and when drunk he constantly demands that others become as happy as he, and is quite resentful of anyone who is not.

4. *The child has tremendous feelings about personal invulnerability and immortality.*

It is inconceivable to a child that he himself will someday die or even that he himself can be badly hurt. A child literally feels that he will live forever and that nothing can hurt him. Even the child who appears fearful is not so much concerned with the possibility of being permanently and physically damaged as he is being in pain for a short period of time. Even a broken bone to a child is important only because of the immediate pain and not because of any fear of permanent damage. We have numerous examples of how the alcoholic, in spite of his protests to the contrary, also has much the same feelings of personal invulnerability and immortality. An outstanding example is the fact that each time an alcoholic "slips," he is "shocked." He simply cannot believe that after the severe difficulties and pain and discomfort from his previous benders that he could possibly have been so stupid as to have started off on another one. So that each time he goes on a bender and each time he gets sick from his bender, he is surprised and discomforted. This surprise literally comes from the feeling that "nothing can happen to me," which so many alcoholics have.

Another example of this kind of feeling is the statement of many alcoholics that "a drink steadies me down." Although it is quite obvious to everybody in the immediate vicinity of an alcoholic that when he drinks, he becomes very far from steady. In fact, he becomes the opposite. This seems to have no meaning to the alcoholic himself. Even though he may pay lip service to the fact that he cannot do as adequate a job when drinking, nevertheless, each time he feels that this drink will help him do a more adequate job than he could do without it.

Guilt Lacking

There is one other characteristic of the alcoholic which, to me, does not fall too clearly into the so-called "childish" mechanisms. This is the capacity of the alcoholic to accept a state of "peaceful oblivion" without feeling guilty about it. To most people the idea of a state of complete oblivion carries so much of the concept of helplessness that they will struggle against it or if they accept it they do it with considerable feelings of guilt. The alcoholic, however, has the enviable capacity to accept this state of either escaping or releasing tension without feeling either helpless or guilty for feeling helpless. This does not mean that the alcoholic does not feel guilty for what he does when drunk, but he does not feel guilty for the state of "peaceful

(Continued on page 30)

What we are is God's gift to us and what we do is our gift to God—

Don McNeill

Interview with RAYMOND G. McCARTHY, Associate Director, Yale Summer School of Alcohol Studies, Associate Professor of Health Education, Yale University

ALCOHOL EDUCATION IN OUR SCHOOLS

What is being done in our public schools about alcohol education? Are the true facts about alcohol being taught? A noted specialist in the alcoholism field answers many of your most-asked questions in this exclusive interview with a member of the ARP staff.

Mr. McCarthy, is teaching the facts about alcohol a function of public schools?

Most people do not realize that every school system is required by law to devote some time to instruction about alcohol in the elementary grades. In about half of the states there is a similar requirement for instruction at the high school level. Just how effective our school systems have been in carrying out this law is open to question. For example, if you ask the average adult whether he recalls hearing or taking part in a lesson or two about alcohol in the elementary grades, it is quite likely that he will not be able to recall any such experience. This, of course, does not mean that such instruction was not given, but there is evidence that, particularly in the years 1920 to 1940, little attention was paid to this subject beyond the limited amount of material that was found in the elementary physiology and hygiene books. I think the situation has changed considerably in the last decade.

In those places where it is a function, are they doing an adequate job?

Well, that is a difficult question to answer because it would be necessary to visit many of these schools in order to determine how adequate the job is. It is my impression, however, that an exceptional piece of work is being done in a number of our states. Their approach to the teaching prob-

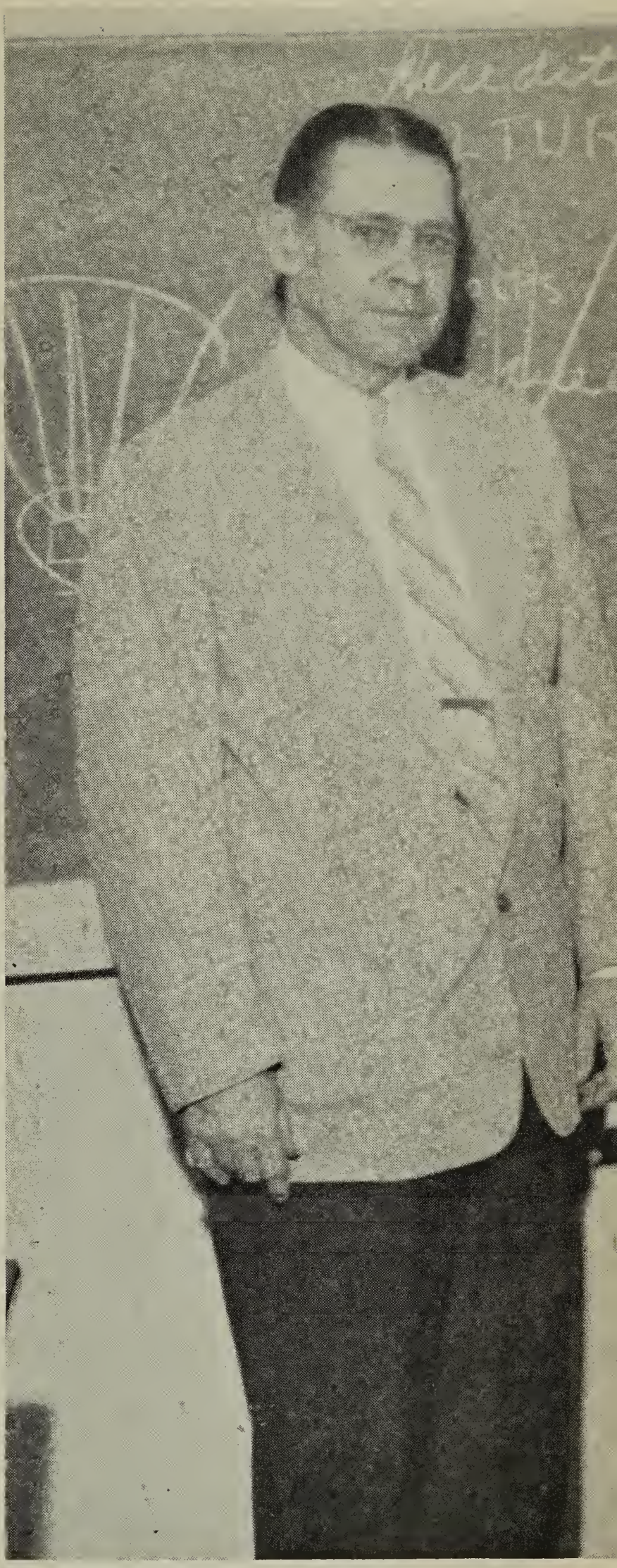
lem varies, the emphasis varies, and the amount of time and personnel they have available differs widely. However, if you look into the situation in Oregon you will find that for the past 7 or 8 years, courses on an extension level designed for in-service training of teachers have been offered. Close to 900 teachers have taken advantage of these courses and so far as I know are using some of the material in their classrooms. Other states such as Mississippi and Vermont, Alabama, Ohio, and North Carolina, have made great headway in instruction about alcohol. I think their emphasis has been not only on the training of teachers, but on the preparation of materials, acting as resource people to the local systems and, in general, encouraging the development of more adequate teaching.

You can certainly say there have been a great many improvements then, over the past.

I would think so, yes.

What have been some of the traditional limitations to effective classroom instruction about alcohol?

I think it is only fair to say that some of the limitations in instruction about alcohol may be considered characteristic of instruction in other areas. As you know for many years the concept of schooling, namely, exposing young people to a systematic arrangement of ideas, was considered to be the basis of good teaching. We know that is not a fact. We have known it for sometime and we have modified our teaching in such fields as reading, spelling, in the organization of materials in the fields of social science. I think there are



RAYMOND G. McCARTHY

two aspects to the traditional approach to the field of alcohol. One has been this lecture, pouring-in process by which accumulation of facts was assumed to be developed on the part of children which in turn would modify behavior. Secondly. I think the overstress on the physiological action of alcohol with relative indifference or lack of awareness of the social implications of the use of alcohol, and the abuse of alcohol, are persistent in many of our schools. We know today that an intellectual understanding of a behavior situation does not necessarily change behavior. I think we have been rather slow to recognize that in the instruction about alcohol.

We know that there have been some recent improvements in the tools or techniques of teaching. How have some of the recent teaching techniques been integrated into the classroom instruction about alcohol?

Well, I suppose the major improvement has been in the area of trying to work from the interest and needs of students rather than from the interests and needs of adults. By that I mean that in the past it has been assumed that adults could organize concepts around the use of alcohol which they felt young people ought to accept and then we have so organized them and presented them to young people. The fact remains that many times, although they were worthy objectives, they were outside the range of interests of young people and hence were accepted intellectually and rejected emotionally. I think there are two outstanding developments in terms of techniques

Teachers find that student participation, such as poster making,

and they are not peculiar to the field. One is the technique of working through student committees, through student interests, through encouraging young people to explore and develop and formulate concepts for themselves rather than being handed them ready made. Second, I think the use of techniques such as role playing, preparing radio scripts, preparing television scripts and sometimes broadcasts, use of tape recordings or the use of visual aids in general has had an effect of lifting this material out of the rather unrealistic, and I would say uninteresting, area to young people and making it more realistic and more livable in terms of their own needs.

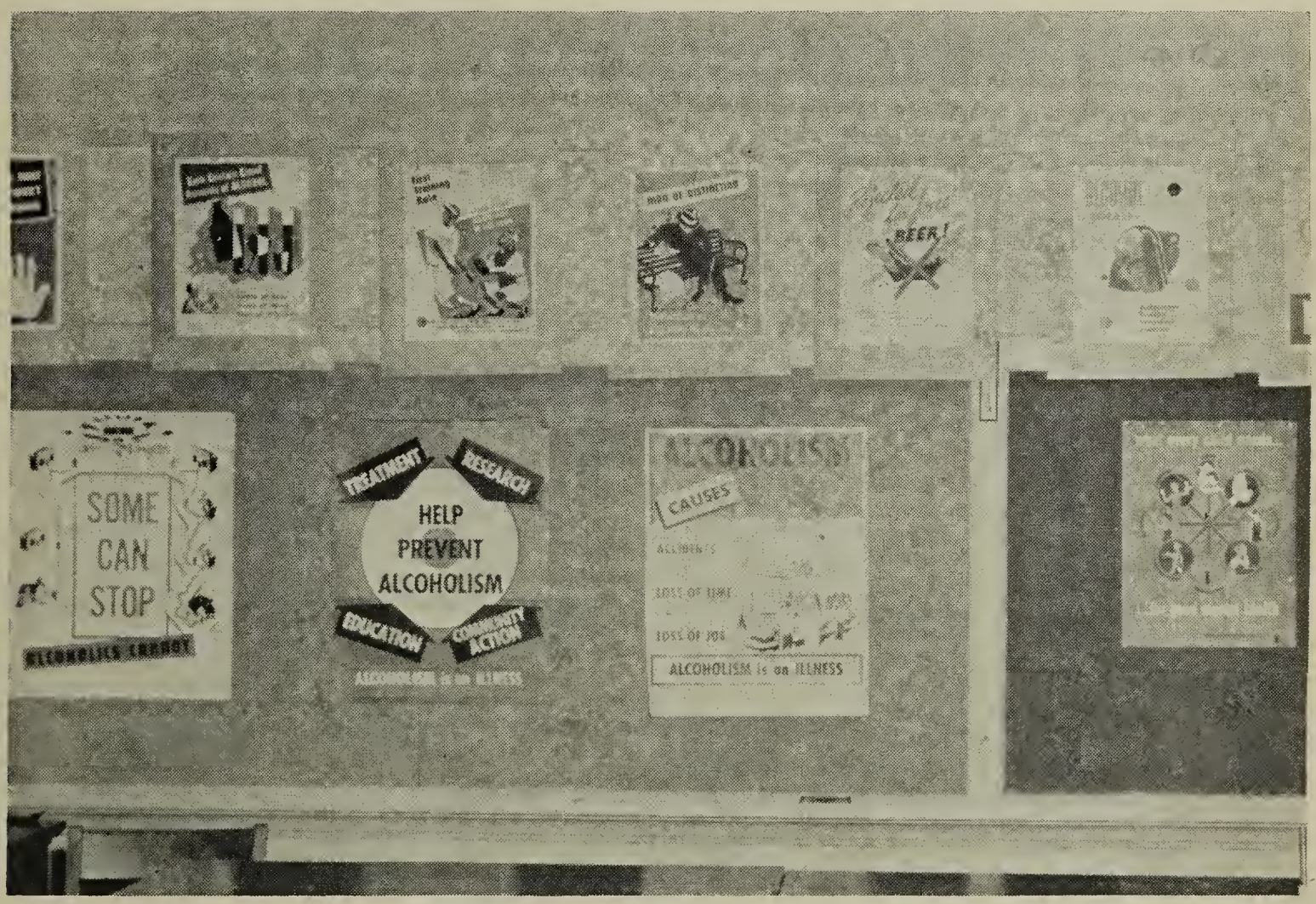
Are these new techniques and materials being made readily available to teachers?

I think it has been rather difficult in the field of instruction about alcohol to do the kind of thing that is possible in mathematics, in science, physiology, namely, to develop visual materials. Traditionally we were dependent upon such materials as laboratory demonstration of the animal, organic, vegetable material and the effect of alcohol in high concentration upon it. The lack of validity of such demonstrations has been explained and, I think, accepted. But when you get into the field of social behavior of subjective feelings about one's self in relation to other people, it is much more difficult to set up experimental procedures.

Should teachers take sides in the "wet-dry" issue?

This is a difficult question for

is an effective method to use in teaching facts about alcohol.



many people. It seems to me that teachers are people, that they reflect the background from which they develop, the points of view that were presented by their family and community, the church, all of the influences which affected them in their early years. I would be inclined to believe that teachers do have strong opinions on the wet and dry issue and I am sure that some teachers carry these attitudes into the classroom. However, I think, and hope, that since most teachers have had some training in the handling of controversial issues they are able to present or provide an opportunity for young people to acquire information and evidence and to some extent attitudes which are relatively objective and which will lead to the young person's making the decision rather than the teacher making it for him.

Do we have any indications as to how effective the old approach to alcohol education has been in influencing the attitudes of young people towards drinking?

Well, it is a little difficult to answer that question because it might almost assume that the school was the sole influence in determining the attitudes of young people. We do know this—that the use of alcohol by the young people in the age group 20-29 is considerably higher than in other age groups. If this reflects a failure or a lack of effectiveness on the part of school instruction, I suppose it might be looked upon as such. As a matter of fact there are so many other influences that determine behavior whether it is in the field of the use of alcohol or in other fields that it is a little difficult to answer the question. I feel that whatever the technique of the past has been, we can be more effective.

What suggestions can you make to improve our program of alcohol instruction in the school?

I think we need to recognize that the school reflects the community. It cannot move faster than the community without difficulties arising. On the other hand, I think the school has tended to isolate itself from the community, particularly in questions as explosive as this one. It seems to me that we have two major needs. The first is the matter of teacher-training. Traditionally there has been little emphasis on this subject in teacher training institutions although that is where the greatest emphasis should be given. I think we have already mentioned in-service training of teachers in other states. I think this should be expanded. I recognize that this is extremely difficult because teachers are busy and have responsibilities in other areas. I think that there should be more teacher planning within the schools on material to be offered and the responsibilities of every teacher. I think this should be related to the community, or community representatives should be encouraged to participate in such planning. I think the school can then go just as far and as fast as the community is able to allow. I think in the long run this will be the most effective approach.

Before you flare up at anyone's faults, take time to count ten—ten of your own.

YOUR PSYCHOLOGICAL FIRST - AID KIT

BY Wm. B. TERHUNE, M.D.

To heal the wounds of emotions you'll need to fill your kit with the correct mental equipment.

YOU, like everyone else, will at some time in your life come up against emotional problems with which you need help. And you are very likely to be called upon to help friends or relatives in similar need. Now is the time to provide yourself with the correct mental equipment. We all have potential psychological equipment, but we must develop it and learn to use it automatically. So you must develop skills in personality and acquire techniques before you can help yourself or others. Your first-aid kit must have these essentials:

Absolute integrity is a sine qua non. To attain this integrity you may cut no corners, steal no bases, no matter how great the temptation. Your first step is to seek the truth about yourself, or about those you want to help, realizing that truth is

elusive and must be sought out. Once you have found it, adhere to it firmly.

You must have a *desire for knowledge,* an intellectual objective curiosity, a wish constantly to find better methods of making personal adjustment. Watch the good adjusters, discover how they do it, and imitate them. Three-fourths of learning consists of imitating that which other successful and intelligent people have discovered. So try really to *understand* yourself and others, why people act as they do, what makes them tick. In general, the truth about people is simple, uncomplicated and easily understood—therefore often overlooked.

A Valuable Trait

Loyalty is one of the most valuable of all sentiments—valuable to yourself and to others. Everyone has a degree of loyalty, but perhaps you have not yet developed it or learned to use it wisely. The acme of this virtue is to support all things that merit loyalty, so try to think and speak no evil of anyone. If you are helping others, build them up by mentioning their good points, no matter how great their faults. Destructive criticism indicates your awareness of your own shortcomings, which you simply evade by criticizing others. The loyal person can be trusted at all times, and—what is more important—he trusts himself.

Whoever is loyal, whatever be his cause, is devoted, is active; he surrenders his own self-will, controls himself, is in love with his cause and believes in it. Thus, inability to make decisions is often corrected by loyalty; for the cause plainly tells the loyal man what to do. Loyalty tends to unify life, to give it contour, purpose, stability.

If you have a friend or relative with an emotional difficulty, *skill in listening* is an indispensable asset. It is characterized by showing more interest in others than in yourself. The good listener will ask but few questions; he speaks only to maintain the friendly atmosphere which acts as a warm poultice for drawing the other person out. A skillful listener seldom makes comments, gives little advice, and above all does not talk about his own experiences and beliefs. This requires patience, an open mind and mental flexibility. Important matters cannot be hurried; it takes time to establish a helpful relationship between a sympathetic listener and a person who needs to talk. Just as the miner in search of gold works many a panful of sand before he finds a nugget, so it is the persistently patient listener who is rewarded. An open mind is useful because—among other benefits—it attracts other people's ideas, but the mind can be kept open only if none of the corridors are blocked by fixed ideas. To help others, you must learn to give unprejudiced consideration to things you do not like; look for the truth or beauty that others believe they find. The third requirement for skilled listening, mental flexibility, indicates a willingness to exert yourself sufficiently to look at all the angles of a situation. As a corollary, with mental flexibility goes a willingness to admit error ungrudgingly and, if necessary, frequently.

"I will sing with the spirit, and I will sing with the understanding also," said St. Paul. *An understanding spirit,* desirable though it would be in everyone, is absolutely necessary for anyone who wants to help himself and others psychologically. People seek money, fame and position, hoping thus to outfit themselves attractively in the sight of others. An understanding spirit would be a bet-

ter goal, but in the quest for transient material success this enduring quality of personality is too often forgotten. Understanding yourself is largely the result of *wanting* to enough. To understand another, it is necessary to put yourself in his place, to try to feel as he does, to see things as he sees them. Understanding does not depend upon sympathy, which is a poor substitute for putting yourself in another's place—since sympathy may encourage self-pity, the most malignant of all sentiments.

Live With Others

All people have a deep need to be understood. To understand, it is necessary to live mentally on the level of others, and to feel with them. Thus only can one assuage another person's aloneness —the most painful void in man's life.

Tolerance is not only a tool but the hallmark identifying a sterling character, an individual free of the dross of prejudice, one who gives to others the same complete freedom to believe and to live as he truly thinks right for himself. In dealing with yourself, as with others, tolerance is a necessity, for it clears the atmosphere so that one may see far into the distance. First recognize the advantages of being tolerant, then wish to be tolerant and try to become so. Seek and obliterate ruthlessly all intolerance that you can find within yourself. Realize that every intolerance is wrong and that, as long as even one remains, it will obscure your vision in some direction.

Efficiency in one's own life is important since much suffering and misunderstanding is due to careless inefficiency. As a nurse must be able to put a bandage on securely and quickly, so you, who are trying to help yourself or your friends, must use the appropriate emotional adhesive, must be able to apply an idea deftly so it will stick. Learn to be efficient; do things the easiest and simplest way; minimize the effort involved; enjoy doing each job better. Much of the satisfaction in life lies in accomplishing a purpose simply and efficiently. Once you know *how* to do it, "easy does it," and life becomes increasingly satisfying. The height of efficiency is casual efficiency. Try to accomplish your purpose with the least and best effort—and help others to do likewise.

Humility is the mark of a truly great personality; no small person was ever humble in spirit. The humble person acknowledges failure and success without being unduly cast down by the one or set up by the other. He treats criticism and flattery in a similar manner. He knows that human action is imperfect more often than not, and that he is responsible for his purpose but not altogether for the results—provided the purpose has been diligently and efficiently sought. People with true humility are usually kind, and everyone feels a binding affection for them. Humility is a conspicuous trait in the character of a mature person.

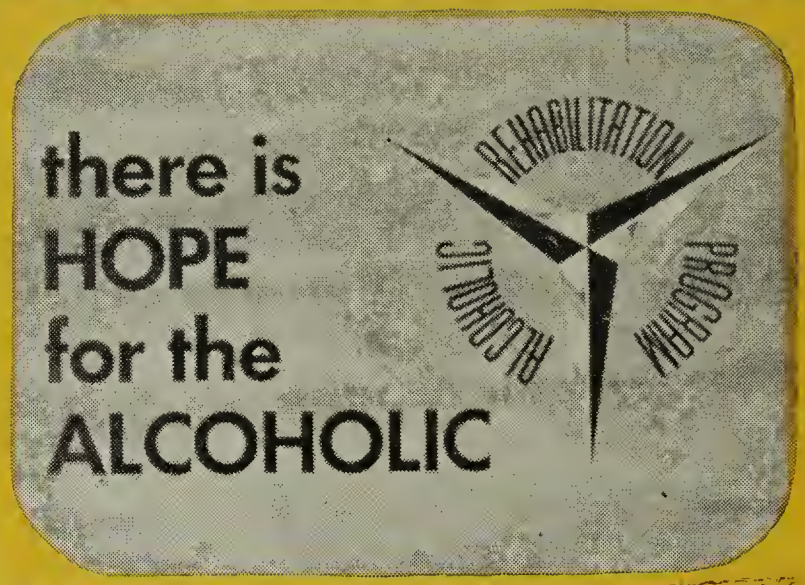
Judgment Valuable

Good *judgment* is an invaluable asset and to possess it should be everyone's goal. Fortunately, good judgment can be acquired through training and practice. Thus, take time to think through even an emergency, then check and recheck facts and decisions. When called upon to handle an emotional emergency of your own, ask yourself: "Does what I am about to do show good judgment? Would a jury of good, wise, and experienced men and women agree that this is the wise thing to do, for everyone concerned?" Start

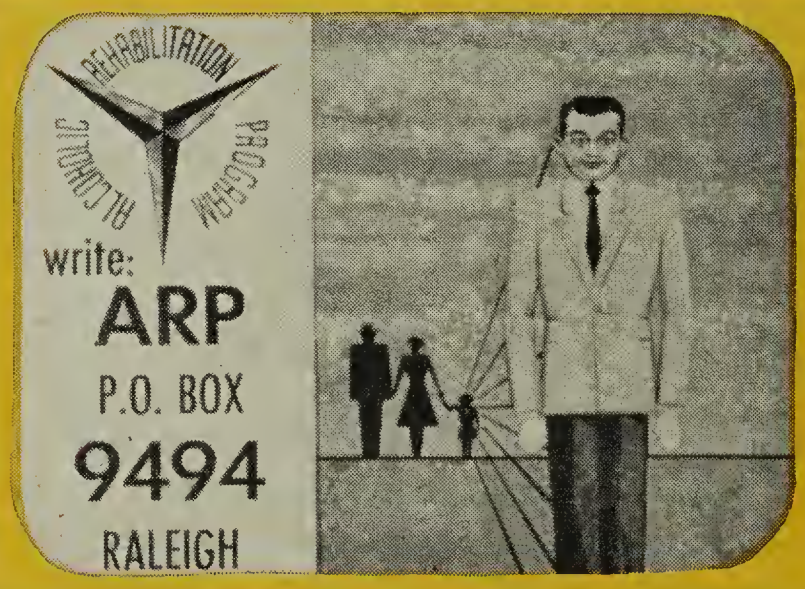
(Continued on page 32)

ARP takes to the air!

On June 1, the ARP branched out into a new field of communications with the showing of these TV slides on every television station in the State — eleven in all. We'd like to thank these stations for their cooperation and our special thanks go to WRAL-TV staff artist, Bill Pugh, for his art work and constant supervision.



The Star of Hope, symbolizing a happy future for the alcoholic through the work of your state alcoholism program. The alcoholic can be helped — through treatment, education, prevention and research. For information about the Rehabilitation Program, Write Box 9494, Raleigh.



Is this man familiar to you? Is he anyone you know? He is an alcoholic. He suffers from one of the largest public health problems in the nation. He's a compulsive, uncontrolled drinker and he's sick. You can help him through your understanding. Write the state alcoholism program for details.

one person suffering from alco-
dditional **five** persons are affect-
child is not immune from the
put on this illness. Alcoholism
m of every person in the com-
rn how YOU can help. Contact
is hope for the alcoholic.

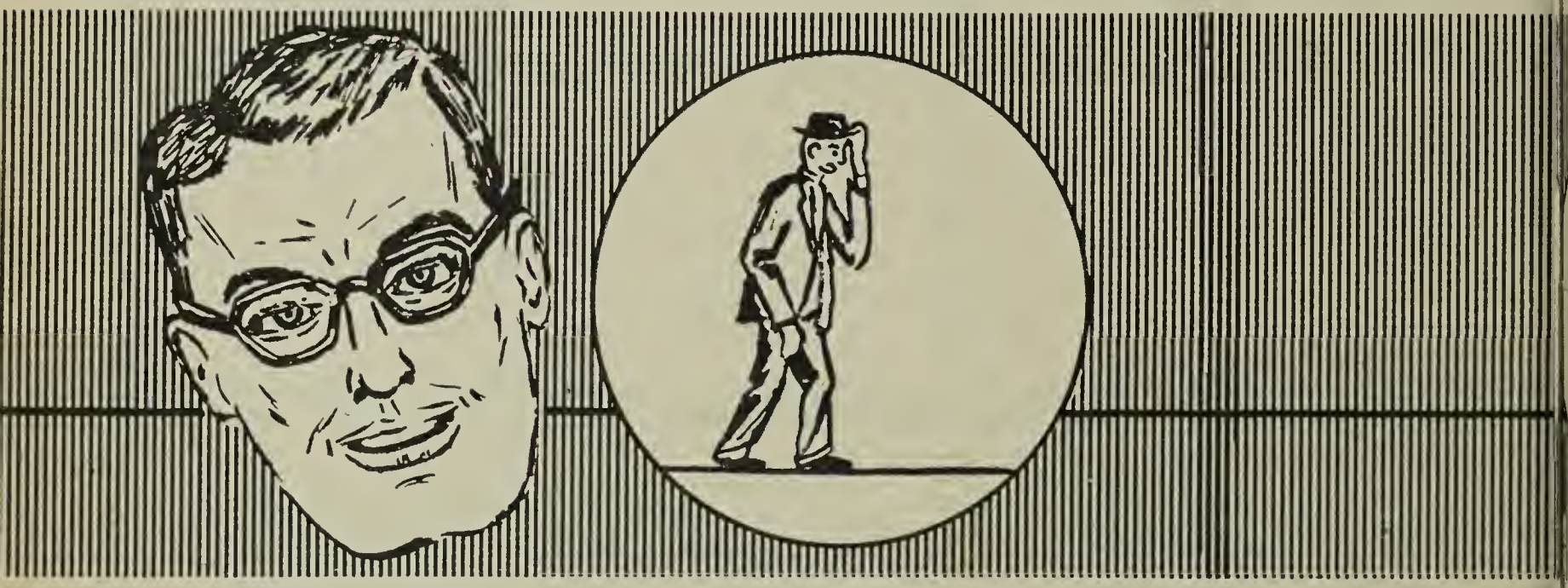
Warning! Alcoholism is an illness that can happen **not only** to your neighbor. It could happen to you! Know the warning symptoms of alcoholism. It's a deceptive disease developing slowly and progressively. Write your state alcoholism program for information. There is hope for the alcoholic.

hysician is as mindful of the
eeds of his patients as he is of
To the alcoholic and his family,
ich help and understanding. The
ician is a valuable member of
eam, working to wipe out alco-
the ARP for information.

Well-adjusted men and women don't just happen. They're the product of an understanding home and community. Prevention of an emotional illness such as alcoholism begins with the family. Write your state alcoholism program for information. There is hope for the alcoholic.

Progress

IN THE TREATMENT



IN the history of alcoholism the first half of the 20th Century will go down as the period which saw a gradual general acceptance of alcoholism as a disease.

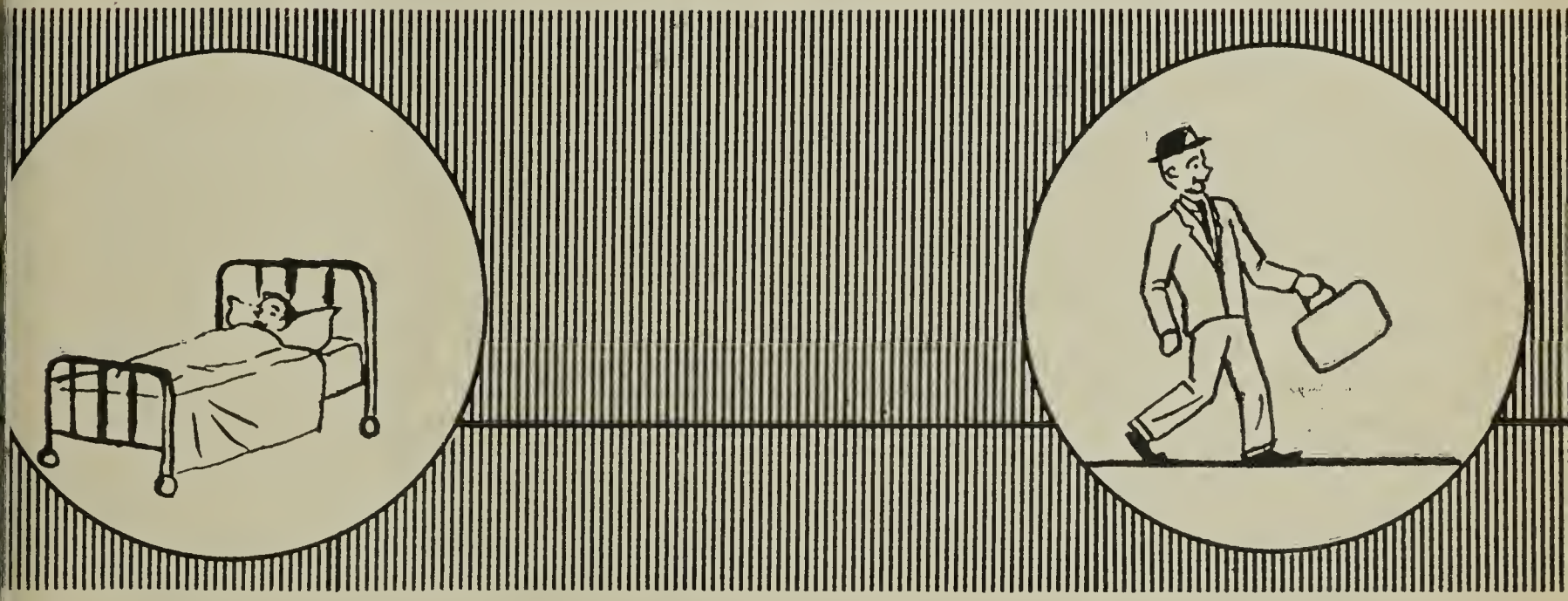
The mere recognition of alcoholism as a disease is a tremendous step in itself but it is certainly not enough. It would be equally wrong to claim that the alcoholic should be the exclusive property of the physician, when in fact the symptoms of alcoholism are so manifold. Certainly alcoholism must continue to claim the attention of many people, both lay and professional. In the latter group we would include the sociologist, the social worker, the minister, the psychologist, the economist, the journalist, the anthropologist, the law-enforcement officer and the legislator. These and many others must communicate their own special knowledge of alcoholism '

The medical profession has been slow to accept working with the alcoholic as part of its daily duty. But now, in mid-century, many hospitals will accept the alcoholic patient and the doctor who turns his back on the alcoholic can be regarded as not only unethical but also as probably an emotionally sick man himself. In general, the responsibility of the medical profession has focused upon the physical condition of the alcoholic. Often the despair and despondency of the physician is related to his repeated experiences of sobering up the alcoholic and discharging him

Treatment is improving and with it comes a change of thinking that could mean quicker and more successful recovery for the alcoholic.

BY JOHN A. EWING, M.D., D.P.M.

OF ALCOHOLISM



from the hospital physicially fit to start drinking once again. The average physician feels (with some justification) that there is only so much time that he can afford to give to the alcoholic patient and he welcomes any apparent short step to the treatment of the alcoholic. He readily accepts the new approaches which enable him to do something quickly with and for the alcoholic and then dismiss him from his office without "getting too involved". The drug antabuse has certainly proved a great boon in this respect as have the various tranquilizers.

To a very large extent, however, the members of the medical profession who spend most time with any individual alcoholic are the psychiatrists, assisted by other professional workers such as the nurse, sociologist, social worker, and psychologist. However, there are many psychiatrists who themselves are unable to tolerate such work. But if every psychiatrist in the United States were to give up all other work and to spend his entire time treating alcoholics, and if all alcoholics went to these psychiatrists for treatment there would still be a grossly inadequate amount of treatment available. Assuming that each psychiatrist were to work a 40-hour week, a rough calculation at once shows me that each alcoholic would receive a one hour interview from a psychiatrist approximately every 10 weeks.

In spite of the inadequate number

of psychiatrists available when compared with the number of alcoholics who might wish to seek treatment there is one very important step that I feel we must take in the second half of the 20th Century. This step is based upon the findings of those psychiatrists and their alcoholic patients who have been able to work together. It has become increasingly clear that the old catch phrase "alcoholism is a disease" is an unsatisfactory one and should be replaced with, "alcoholism is a symptom."

What Is A Symptom?

My dictionary defines symptom as "any perceptible change in the body or its functions indicating disease, or the kind or phases of disease." In the practice of medicine the physician uses the symptoms and signs which appear in his patient to track down the causative disease, to enable him to diagnose that disease and hence to treat the basic causal condition itself.

As an example, let me cite the symptom of fever. When the physician finds that the patient's temperature is consistently above normal he sets to work to find out why. The physician must find out the origin of the raised temperature. Is it appendicitis, tonsillitis, pneumonia, an abscess, or one of many infectious diseases? Reaching an answer may be relatively simple or enormously complex. The possible causes of a fever are legion and the physician's diagnostic training is aimed at using all the signs, symptoms, clinical examinations, and laboratory examinations at his command in order to reach a final decision as to the cause.

When it comes to alcoholism we are a long way behind the general stream of medicine. There is still a tendency among the medical profession and among people in general to regard the removal of the symptom as an end in itself. Just getting an alcoholic to stop drinking may seem a very desirable result. But what will this mean if the drinking has been this alcoholic's only major solution to dealing with unbearable tensions? Sometimes it may result in the development of some new emotional symptom or one of the so-called psychosomatic diseases. Of course not every alcoholic will necessarily respond with sobriety to treatment which is just aimed at the symptom of his drinking. If the drinking is a kind of emotional fire-escape (and the only one he is able to use) he will almost certainly use this again once his "nerves" start shouting "fire!"

Varied Approaches

Fortunately, many of the treatment approaches which are only intended as symptomatic treatment turn out to have other connotations. Let me give a few examples:

The so-called aversion treatment of alcoholism was developed on the theory that a "conditioned reflex" might be set up so that the patient would feel great repugnance and even become physically ill when contemplating taking a drink. As far as this goes it is purely a symptomatic treatment. However, this treatment has to be administered to the alcoholic by one or more people. At once we are dealing with the most complex of all treatments—the interpersonal relationship. Here we are concerned with the powerful psychological effect of one human being upon another. Fortunately, this relationship is one of primary interest to the psychiatrist, and psychiatric teaching and attitudes are gradually being brought back into the medical profession. In writing of general prac-

titioners quite recently Michael Balint, a psychoanalyst, stated that the most frequently used drug is the doctor himself!

Take, as another example, the situation where the physician gives the patient a "tranquilizing pill" in an effort to help him with his alcoholism. We know from studies that the success or failure of the tranquilizing pill will depend much more upon the meaning of the patient's relationship with the physician rather than the activity of the drug. Just recently a physician, H. Koteen, has reported a scientifically controlled study which failed to show any better results from inactive tablets when compared with one of the much advertised modern tranquilizers. He concluded that the tranquilizing effect of a pill depended more upon the association with the physician in which the patient "gains a sense of security from a visit with a compassionate person."

Psychological Factors of AA

As a final example of a treatment method which is seemingly aimed primarily at the symptom of drinking let me take Alcoholics Anonymous. In this fine organization it is at once apparent to any really participating member that psychological factors and psychological relationships are supreme. I feel confident that the A.A. movement would have failed had it merely preached (as had other movements before it) the doctrine of sobriety. Instead, what the Alcoholics Anonymous Organization has to offer the alcoholic is psychologically vital. The successful A.A. member accepts a dependent relationship upon an accepting group. He accepts his inability to stand strictly alone. He accepts the support from others and his responsibility to others. In his relationship with the group he may become a very active leading figure or just one of the back seat members. Whatever he does there is no doubt that affiliation with the group has its major effect in psychological terms.

Of course Alcoholics Anonymous membership is not the answer for all alcoholics. The psychological meanings of A.A. while acceptable to so many, still frighten away a few. This is true of any single treatment method aiming at the problem of alcoholism. In many of our large-scale attempts at alcoholic rehabilitation either at Centers or on an outpatient basis we tend to use one major treatment approach. This is forced upon us because of small numbers of therapists and large numbers of patients. Certainly, some people will benefit from a treatment program just because the psychological meanings of that program happen to fit their needs. However, there are other patients whose psychological needs will not be met by a program aimed just at the masses. An analogy which comes to my mind would be to issue one standard type of glasses to people with poor eyesight without ever attempting to measure the eye defects which have to be corrected. Some patients would feel that they could see better with these standard glasses but others would find no benefit and some might even see worse.

Enthusiasm Needed

For many years I, and other psychiatrists interested in alcoholism, have been saying that the results of any one treatment are directly proportionate to the enthusiasm of the person offering that treatment and the effects of the enthusiasm upon the relationship with the patient. Another thing which has been clinically apparent is that the particular meaning of a type of treatment may

be acceptable to (and hence good for) one patient but unacceptable and unsuccessful for another.

This last point leads to the main purpose of this article—to make a plea for a further advance in the treatment of alcoholism. I have said that at first we had the statement "alcoholism is a disease." Then came, "alcoholism is a symptom of underlying emotional maladjustment." Now, I think, we must move toward the next phase which is "Adjust the treatment of the alcoholic according to his underlying emotional maladjustment." In other words I am advocating the need to study the patient in more detail, to delve below his symptom of alcoholism, to define the particular cause of his alcoholism and then to offer treatment which is specifically aimed at that particular personality and its psychological needs. While this general program has been clear in the minds of many of us for some time we have been a long way from its becoming a reality except on a relatively small scale and in a few places.

Important Research

Now, however, we are faced with a vitally important piece of research which is reported in a publication* of 1957. In spite of the title of this book Dr. Wallerstein and his colleagues are not offering directions for the physician on how to handle the hospital treatment of alcoholic patients. The physician who wishes to know anything about the treatment of delirium tremens or alcoholic shakes must look elsewhere. This book does not answer as many questions as it raises but nevertheless it is one of vital importance because of the significance of the work therein.

This is the report of a research project carried out at the Winter VA Hospital, Topeka, Kansas. Four different treatment methods were used —antabuse, conditioned reflex therapy, group hypnotherapy, and a control group. The last group was supposed to receive no specific therapy and to be there for comparison purposes mainly. However, as I have indicated above, it is impossible to have any meaningless human relationship. Therefore, this group, while continuing to be the control group for comparison purposes, developed into that receiving "milieu therapy" with group discussion predominating.

Test Cases

Patients were randomly assigned to one group or another for a hospital stay of 60 or more days. All patients were studied psychiatrically in considerable detail and were followed for two years after cessation of the treatment period. While antabuse was apparently more helpful to more patients than any other single treatment method it is equally clear that antabuse is by no means the answer to the problem of alcoholism as nearly half of the patients receiving this were not helped. Also, all the other treatment methods helped a significant number of patients. This led these researchers to analyse their results in sufficient detail to show which types of patients did best with which type of treatment. I will not attempt to give these workers' conclusions in detail. The reader whose interest is stimulated by this review should study the original. However, a few of the conclusions are worth recording here.

The dimension of compulsiveness

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*"Hospital Treatment of Alcoholism" by Robert S. Wallerstein, M. D. and associates. Published by Basic Books, Inc., New York, 1957. Price $5.00. 210 pages.

proved to be a measure of good prognosis with antabuse but it cut across diagnostic groupings. On the other hand patients on the border of a depression or of a psychosis did not do well on antabuse, which seems to present the danger of precipitating a psychotic reaction. Such patients did better on milieu-therapy. The more passive dependent the patient the greater chance he has of benefiting from hypnotherapy. Schizoid patients seem to respond to this treatment also but appear to be unable to maintain improvement after discharge. The patient with overt depression seemed to respond best to conditioned reflex therapy.

Patients with strong aggressivity were problem patients in whatever group they were assigned but did least well in the groups receiving reflex therapy and hypnotherapy.

One factor which over-ruled all these considerations was the fact that prognosis was better in patients who had a greater capacity for meaningful interpersonal relationship and a greater potential for forming a dependent tie to the therapist and to the hospital.

The importance of this work cannot be overestimated. The results clearly suggest that by classifying the patient by his personality type we may be able to offer him a specifically planned treatment program which is most likely to be helpful to him. The work which is reported in this book should certainly be repeated elsewhere and Wallerstein and his colleagues are the first to admit this need. However, we are dealing with a major breakthrough in the field of alcoholism therapy. One can conceive a patient being admitted to a rehabilitation center where he is studied in detail for several days after which he is assigned to one of several treatment groups according to his psychological make-up. These treatment groups would each offer a treatment program specifically designed for the personality make-up of the assigned patients. This is not to suggest that individual psychotherapy should become a thing of the past. But we are faced with tremendous numbers of people suffering from alcoholism and we must consider how we can improve our mass treatment methods which are presently being used in many rehabilitation centers.

Certainly we are justified in concluding that a specially tailored program where the individual is treated along with a group of people of similar personality make-up would probably improve the results in any treatment center which at present offers relatively unspecific therapy on a take it or leave it basis. This hypothesis is readily subjected to experiment and undoubtedly much more will be heard of this Wallerstein Study and of studies growing out of it in the years to come.

MIND AND BODY

PSYCHIATRIC treatment is far from treatment of "the mind" alone. While it is essentially causative treatment, the psychiatrist as a physician uses all of the techniques of medicine. Adequate rest, achieved usually through drug therapy, vitamins, and proper diets to overcome the deficiencies and underweight common to problem drinkers, are equally his concern.

—from THE PROBLEM DRINKER
by Joseph Hirsch

THE STORY

BY JIM O.

Reprinted from BAR-LESS published by Indiana State Prison AA Group.

THERE is a story that belongs back of the bottle . . . I am speaking to those now who are true alcoholics. If you do not realize this, you will revert to the bottle every-time unless you recognize what is wrong with you as an alcoholic, what is wrong with you inside. I do not care what you call that inside depart-ment, whether you call it emotion or spirit, or whatever you want to call it, it doesn't make much difference. But until you are willing to admit as a human being there is more wrong with you than drink, your chances of staying away from the bottle are nil. That is one of the hardest things in the world for the alcoholic to grasp. Almost all of us who are alcoholics have friends and kindly relatives, loving mothers who are willing to say: "Isn't it too bad about Jim for he could be such a good guy if he didn't drink so much." The alcoholic buys this nonsense that the only thing wrong with him is: he drinks too much.

Watch the alcoholic who is abstain-ing from drinking, who is dry. I am sure you will see a miserable tor-tured man. We used to say in Chica-go that if all an alcoholic did to stay sober was to stay away from the bottle, he hadn't done anything at all. If taking the bottle away from the alcoholic is all you are going to do to help him, giving him nothing

BEHIND THE BOTTLE

The salvation of the alcoholic lies in his recognizing that there is more to his problem than just drinking. An alcoholic frankly tell us why.

to replace it with, you wouldn't be doing him a favor at all. If that is all you are going to do for the alcoholic, for God's sake let him drink. He needs something to rely on, to carry him through life. If you will look at the reason why you drank, you will find that alcohol performed a very valuable service to you.

Alcohol A Booster

Most AA's do not hate alcohol. They recognize through many years booze was their friend. I know in my own case, there are many things I could not have done if alcohol hadn't given me the boost to do it. I would not have had the nerve or courage to carry them out without its help. It made the way easy over the rough spots in life. It calmed my nerves. In my younger days, and perhaps a little now, I was very shy and bashful with gross feelings of inferiority. Surely, some of you are familiar with those feelings? I was always uneasy and nervous and always carried within me the feeling of a fugitive. I kept going through life looking over my shoulder somehow or other. Very early in the game, I learned about six shots of the wonderful stuff and these feelings I had vanished.

It wasn't the taste or flavor of bourbon that I was after, but the feeling I got when I drank it. It gave me a feeling of peace and calm, which I was seeking. When I needed it, it gave me courage and the nerve to do things that confronted me. I could not have done them if I were cold sober. This is why the alcoholic drinks. The feeling is so valuable to him, he has such a tremendous need for it, he will gamble with everything in life to get it. The alcoholic will throw away his family, his respectability, everything, so long as he gets that feeling.

The Awakening

There was an experience I had in one of the hospitals I was in that had a great bearing on waking me up to a few facts. At the time it happened I was quite resentful about it. I had been in this hospital for a little time and one day talked the nurse into letting me see my hospital chart. Here is what I read . . . "Mr. O. is a man of good moral character but he is emotionally immature". I thought, why that dirty so and so. I could have spit in his eye when I read this. I had my clothes in the locker so I put them on and went out and got blind drunk. After about the sixth time of getting drunk like this I sat down one day beside my hospital bed and took a good look at myself. I took a look at the way I had been through the years, the way that I was then. And all I could conclude was, that what I was then, what I

had been all my life was *emotionally immature.*

Now, I think most alcoholics will tell you they sat down and talked to God. To me, God had nothing to do with this nonsense of mine. I think it was six or seven years before I went near a church. The thing that brought me to my senses was the phrase on my fellowship chart, "I was emotionally immature". I was furious at the time I read this for I thought he was trying to tell me in some way that I was stupid. Something was wrong and I knew it, but I didn't know what he meant by "Emotional immaturity".

Today I realize and I am very grateful to that doctor. That was the first time in my life that I had ever had it brought home to me that there was something more wrong with me than what met the eye. There was more wrong with me than just drinking too much.

A Hypothetical Case

What is emotional immaturity? Let's you and I, for just one minute, set up an alcoholic here. We'll create an alcoholic. Into him we will put the qualities that by common concept, everybody agrees belong to the alcoholic. Now these are qualities that belong to everyone in this world. But in the alcoholic, these qualities are prevalant to a different degree than are usually found in other people. But more important than that, the alcoholic is the leopard who has to change his spots. He has to do something about these qualities.

What qualities would you put into an alcoholic? Well, I think you could begin by putting into every alcoholic a lot of selfishness. The very life of the alcoholic will show that he leads a life of selfishness. Always thinking about himself, caring for nobody else's welfare. How about the times the alcoholic leaves his family all alone, the money that he spends drinking that should be used for other purposes? All these things will indicate an intense degree of selfishness. You can mark it down, every alcoholic is an intensely selfish person.

On top of selfishness, put lots of dishonesty. What else? Self pity, and find me an alcoholic here who isn't full of self pity. All of us are. We're highly susceptible to self pity.

What else? Sensitivity? Yes, sensitivity is a good one. Show me an alcoholic who hasn't a sensitive and delicate soul, who isn't always being hurt by one thing or another.

The Greatest Fault

Another one, egotism. Not so much used as a personal pronoun . . . I . . . but let's call it egocentricity. Everything that happens in the world, take that as meaning, as value and importance, depending on how it affects me. He sits in the center of a small circle and everything takes on its meaning, its significance, and its importance depending on how it affects me. This is egocentricity in the alcoholic. I think the greatest fault and the greatest failing of the alcoholic that must be changed if he wants to do anything about his problem is this, the alcoholic is insistent on his own will. He will get that will unless he is restrained as you are here, he will get that will no matter what he has to do. He will beg, lie, plead, threaten, cheat, anything if you will just let him have his own way. And he is just as cute as anyone you have ever seen in getting things his own way.

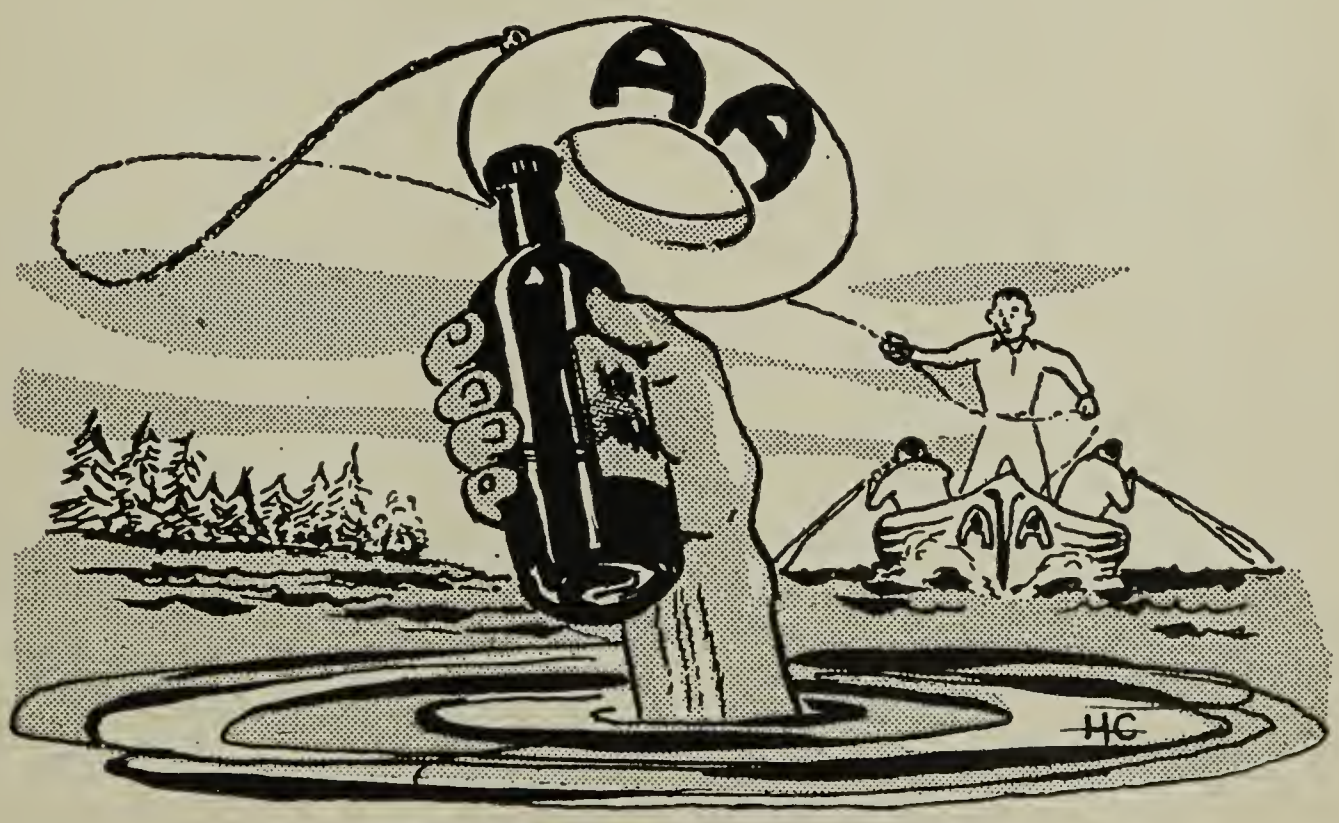
If you want to see a pretty picture, watch the alcoholic who is thwarted in having things as he wishes them. By golly, he'll show you. He'll show you a temper tantrum, he'll get drunk, he'll throw a frying pan, any-

thing, if you thwart the alcoholic in having that insistence on his own way. Hence, the great importance of the Twelve Steps in AA and the third step, "Made a decision to turn my mind and my will over to the care of a Power greater than myself.

But think of the alcoholic that we are creating here. Selfishness, dishonesty, the self pity, the sensitivity, the egocentricity, and this last, this insistence on one's will. On top of these qualities add a few more like love of attention, wanting to be noticed, and the things an alcoholic will do to get noticed. On top of all this put the almost pathological lying that the alcoholic will indulge in. Anything, in the way of a lie. On top of this add deceit, then treachery. On top of this add procrastination, big shotism, and many minor things. Now you create a human being and have those qualities in him, have them grow over a period of twenty years and what kind of guy do you have? Well, let me tell you. You have an emotional scoundrel. I don't care what kind of head you put on him, I don't care what kind of mind he might have. Intellectually and mentally, it does not make a darn bit of difference what kind of head you put on him he is still an emotional scoundrel. This is what the alcoholic has to change.

In AA the Twelve Steps mention drink just one time, because AA recognizes that the problem of the alcoholic isn't drinking. His troubles begin when he takes the first drink, but this problem of the alcoholic is a personality problem, a spiritual problem, it is an internal problem and is always an inside job. And the salvation of the alcoholic, the hope of the alcoholic lies in his recognition that what is wrong with him, is wrong inside.

In AA we have a systematic and sensible, intelligent approach to change human beings. The force of help that is offered comes from others just like yourself. When you recognize this and when you have enough guts to accept the help that is tendered to you, your problems can then be corrected. But unless there is a recognition of it, you and I are dead pigeons.



A guide for the therapeutic agency

HOW TO HELP

The Alcoholic's Family

TWENTY million or more people in this country are suffering directly or indirectly from the effects of alcoholism, according to an estimate by M. Mann (National Council on Alcoholism) in a recent report of the National Health Forum. Of these, some 5 million are alcoholics; the rest are the families or others in close personal contact with them. The need to help these people is obvious—not only because they are so many but also because good mental health in the alcoholic's family, and their understanding of alcoholism, are crucial to the recovery of the alcoholic himself.

Very often it is a member of the alcoholic's family who first comes to a social agency for help. This person becomes the instrument through whom the social worker can get the alcoholic himself to come for treatment. It is a difficult but essential job to educate such a lay person on what alcoholism is, what the alcoholic needs, and how to bring him to recognize his problem. Yet only through such understanding can the family member do his part. Once the alcoholic is under treatment, the proper education and guidance of his family by the physician or clinic staff often affects their attitudes towards him in a way that may be decisive for his rate of progress or even for his chances of recovery. The family of an alcoholic who is well on the way to recovery also needs help in adjusting to the shift in family roles made necessary by his gradual assumption of responsibility.

What should the alcoholic's family be told? A pamphlet written expressly for the families of alcoholics by E. A. Shepherd (Florida Alcoholic Rehabilitation Program) illustrates the kind of information and guidance that the family needs in order to cope with the many problems evoked by the disease itself and by its treatment. The family should have a clear concept of alcoholism as a disease and be familiar with its phases to the extent that they can recognize symptoms, such as sneaking drinks, blackouts, "benders," and vague fears, as facets of the disease, rather than think of them as individual deviant behaviors. They need to understand that alcoholism is not "curable" in the ordinary sense: that the alcoholic will never be able to drink with control; and that no easy pill or injection but a completely revised way of life is necessary for his rehabilitation. They must realize that rehabilitation is not possible unless the alcoholic receives competent help, stays sober, comes to understand why he needed to get drunk, and finally finds in his new way of life satisfactions greater than those he formerly derived from drinking. The public health nurse,

social worker or clergyman who conveys this knowledge is contributing vitally both to the rehabilitation of the alcoholic and the welfare of his family.

Understanding these facts may create a rather depressing view of prospects for improvement; but a falsely optimistic view of the situation, Shepherd warns, can lead to disillusionment which may affect the treatment itself adversely. Realistic understanding is better in the long run.

Shepherd cites six steps pertinent to the behavior and attitudes of the family which the therapeutic agency should attempt to elicit.

First is recognition and acceptance by the family of the fact that the individual is an alcoholic. As long as doubt remains in their minds, treatment will be seriously hindered and may be impossible.

Second, the family can help the alcoholic accept his disease by making literature available; by suggesting a talk with an informed outsider (as a physician, a minister, or a member of Alcoholics Anonymous); and by avoiding threats, which only raise the alcoholic's defense mechanisms.

Third, the "h o m e" treatment should be avoided. This usually consists of lecturing, begging or threatening the alcoholic and trying to manage his life by keeping liquor out of the house or locking it up. None of this will work: the alcoholic will not listen to the talk; he will find liquor elsewhere; and he will resent what he considers to be interference.

Fourth, drinking should be discussed openly and it should be made clear to the alcoholic that his behavior, though arising from disease, is not acceptable to his family or friends.

Fifth, the family must realize that rehabilitation is a long-term project, and be patient. It will usually take the alcoholic some time even to bring himself to accept his condition and seek treatment.

Sixth, the alcoholic must be allowed to take the consequences of his drinking, regardless of embarrassment to the family.

When the alcoholic has begun treatment, Shepherd advises continuous contact between the family and the therapist or the clinic staff, so that they will understand what is going on and receive regular guidance. Now the family should be urged to allow and encourage the alcoholic to take responsibility. For example, when decisions are to be made on whether to drink in his presence, or what to tell friends and neighbors about his disease and treatment, he is the one to make them. Deciding for him, overprotecting him or managing his life will seriously interfere with treatment.

Providing this sort of information and guidance is the responsibility of all professional workers. Family attitudes toward the problem that are based on valid information and real understanding may be the decisive factor in promoting the recovery of many alcoholics.

Program Pointers

(Continued from page 2)

sound. Some sections were vague while some were too binding and far too detailed and one particular bill was far too ambitious and completely unrealistic.

Representatives of the National Institutes of Health suggested the North American Association of Alcoholism Programs poll its membership for opinions regarding the contents of any Federal legislation and

to draft recommendations that such legislation should include. This is an attempt to come to a meeting of minds on the part of state alcoholism programs and the U. S. Public Health Service and its National Institute of Health that an acceptable piece of legislation might be prepared and presented to Congress and thereby forestall the passage of poorer, less acceptable legislation.

As a consequence the legislative committee of the North American Association of Alcoholism Programs is currently polling the membership for opinions and suggestions regarding federal legislation in the field of alcoholism.

The Federal Government realizes vast sums of money from license fees and taxes on the manufacture and sale of beverage alcohol. Only minute and token amounts are being used for education, treatment and research in the area of alcoholism. It seems therefore logical to feel that the Federal Government can afford to increase the expenditure and activity in the field of alcoholism—treatment, research and education. To those of us who are concerned with the sub-speciality of work on alcoholism, it is a problem of sufficient prevalence to warrant and justify categorical action similar to federal programs developed for other problems. In fact one of the basic goals of a request for legislation would be to have the presently established federal health and welfare agencies give appropriate attention and consideration to alcoholism, commensurate with the size and complexity of the problem. It appears to us to be worthy of the energy and time of services traditionally preoccupied with other mental health problems.

For the Director to express his opinions about Federal legislation involves the policy of the State of North Carolina and its program of Federal-State relationships.

The Director has therefore requested an expression from the N. C. Hospitals Board of Control which will allow him to speak for the State in regard to federal legislation on alcoholism, consistent with the policies of our State and the present administration.

A Psychiatrist's View

(Continued from page 7)

oblivion" which he obviously seeks.

There has been a great deal said about the need of an alcoholic to accept himself first as an alcoholic, that is, to admit this fact. In my belief, this is often *overdone*. The very use of the word "alcoholic," has taken on such meaning recently as to make it literally a means of blocking off any possibility of treatment rather than encouraging it. For example, many people who "profess themselves alcoholics" do so primarily to block others, who are not "alcoholics," from helping them. In this way, they maintain their feeling of wishing help and yet at the same time not being able to get it by effectively stopping other people from helping them. When an alcoholic says to me "you don't drink yourself so you probably don't really understand," he is effectively thumbing his nose at me. While I would not object to his doing so, I would certainly doubt the possibility of being able to help him if he continued to do so. I do not labor this point to condemn alcoholics, but only to point out the strength of the need for alcohol—a drive so deep and so strong that it can actually, and frequently does, replace the most basic needs.

The Editor's Page

(Continued from page 4)

viewed saw alcoholism as a medical rather than a moral problem. Since opinion polls are scientifically constructed to sample a cross section of public opinion, we can assume that this is a fairly accurate representation of the views of the U. S. population. This evidence that the moral stigma against the alcoholic is lifting is a hopeful sign. Among other things, it encourages the uncontrolled drinker to face his problem earlier and seek out one of the many treatment channels open to him. As evidence that this may already be happening, AA members tell us that the average age of their new members has been trending downward for the past several years.

There is good reason to believe that the day will come when public opinion will be almost unanimous in its acceptance of alcoholism as a bona fide medical problem. As this trend continues, more alcoholics will be able to come freely into our hospitals and treatment centers with no more feelings of guilt or shame than a patient with any other medical problem.

Secondly, *there is a growing number of treatment approaches and facilities from which the alcoholic patient may choose.* A recent survey showed that in North Carolina alone there are 30 separate facilities for the treatment of alcoholics, exclusive of the numerous AA groups. Each has its own recovery program, using psychiatry, spiritual therapy, medical treatment for acute alcoholism, and many variations of these. One or the other, or a combination of these treatment channels is within reach of almost anyone who needs their services. There are in addition countless professional people—ministers, family physicians and others—who have the proper training and interest to render substantial assistance. No longer does the alcoholic patient who sincerely wishes treatment find his way blocked on every hand. The treatment channels are opening. This is another cause for optimism.

Thirdly, recovered alcoholics living and working in our midst are living proof that *treatment can be successful.* We don't believe any recovery program would claim 100 per cent success, or anything approaching that degree of perfection. But most of the currently accepted treatment techniques are producing a substantial number of recoveries. Alcoholics and their families who still suffer should be encouraged to look around them and be heartened at the sight of others who have thrown off their dependence on alcohol and returned to a happy, productive way of life.

And finally, *research into this complex disorder is beginning to point the way to a more hopeful future.* Admittedly, alcoholism research findings are still meager when compared to the dimensions of the problem. But they are beginning to accumulate. Scientists have turned up some promising leads, some of which will surely result in more effective treatment. For example, in his article in this issue, Dr. John A. Ewing reports the work of a research group who have experimented with different types of therapy to see if treatment can be tailored to fit individual personality types. Dr. Ewing calls this work "a major breakthrough in the field of alcoholism therapy." We recommend that you read *Progress In The Treatment Of Alcoholism* for details.

As more funds are channeled into

research, as more research scientists become interested in alcoholism, we can expect other important and productive discoveries. Treatment techniques and treatment results will improve accordingly.

There is still a long road to travel before this illness will be treated confidently and with a consistently high degree of success. But there are enough bright signs to enable us to look to the future with cautious optimism. So let us not despair.

There is Hope for the Alcoholic!

—G. H. A.

Psychological First Aid Kit

(Continued from page 15)

each day with this prayer: "May I use good judgment in both my small and my large acts."

A *sense of humor* is obviously invaluable. This trait is found in those who do not take life—and more particularly themselves—too seriously. A sense of humor is the balm, the ever-ready healing lotion to be carried by everyone and used on many occasions. Look for the funny elements in everyday living, enjoy the humorous actions of so-called great people, realizing that the world may respect a person for his wisdom but love him for the well-meaning, foolish things he does. Do not be ashamed of making a fool of yourself occasionally; by so doing you demonstrate that you belong to a large and constantly growing fraternity, the Human Race. So make the best of it and help others to enjoy life by constantly accenting its amusing side.

Optimism is always a justifiable virtue. One does not deny unfortunate facts and situations, but having seen them and admitted their unpleasant presence, one should choose to see the good aspects and meaning of life. Optimism is constructive; it encourages the flagging spirit to one more effort, and yet one more, until success wipes out all memory of hardship. Optimism is contagious, spreading its reviving power to all it touches; it is truth in the making. The optimistic person is a joy to others, so think optimistically. Be cheerful and encouraging. Make yourself try; even if you may not attain exactly what you started for, you will reach a destination in which you will find satisfaction. While you are proceeding towards this goal, keep yourself occupied and hopeful. A purpose in life and the attainment of some degree of success, aided by optimism, will stimulate you to further effort and objectivity.

Poise and calmness do much to help yourself and other people. They are contagious emotions which act like oil on troubled waters.

Take Chances

An adventurous spirit is a necessary part of your correct mental equipment. You must be willing to take chances with your own life if you would help others or progress yourself. Life is a gamble; there is little certainty in it, but one can be careful not to play with stacked cards. Let "dare" be your motto. Live with this thought: "I dare to try when something worthwhile may be accomplished for others or for myself. I shall live fully and completely, knowing that life can be a glorious adventure—if only I dare intelligently and in keeping with my ideals."

The well-adjusted person is a *practical idealist.* He believes in and serves others without thought of reward or recognition. His one purpose is *unself-seeking service efficiently rendered.*

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
615 Wills Forest Rd.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-Patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Display—Primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

SEPT.-OCT., 1958

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, an occupational therapist, and ten attendants.

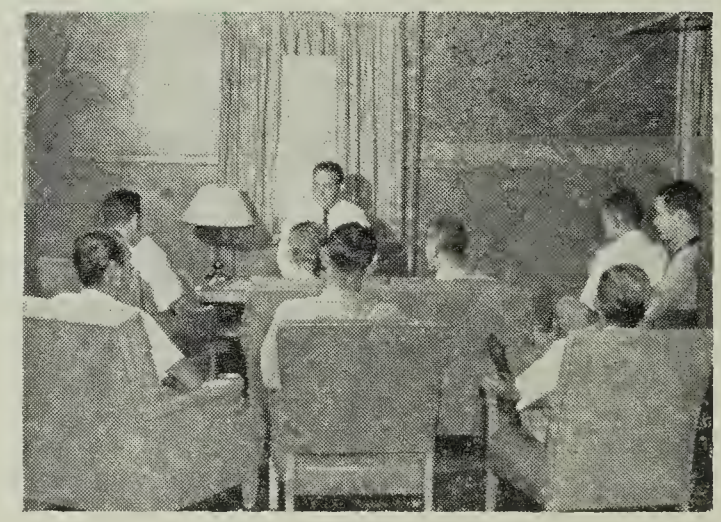
The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday

1 P.M. to 3 P.M. Monday through Friday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Executive Director

DONALD MACDONALD, M.D.
Clinical Director

ROBERTA LYTLE, R.N., M.S.Sc.
Psychiatric Social Work Consultant

INVENTORY

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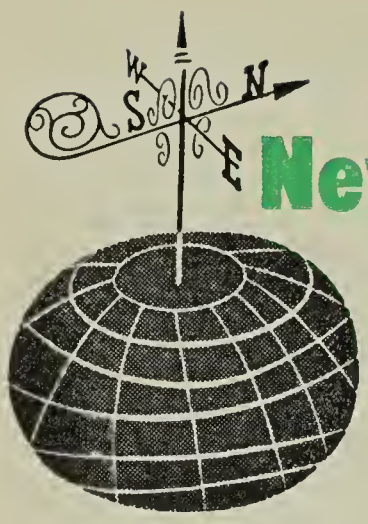


News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

RALEIGH: Norbert L. Kelly, Ph.D. has been appointed Executive Director of the NCARP, succeeding the late S. Kinion Proctor. The appointment was made by the N. C. Hospitals Board of Control, John W. Umstead, Chairman. Since 1952, Dr. Kelly has served with distinction as Educational Director for the Program. His elevation to its top executive post has received enthusiastic approval from friends and colleagues throughout North Carolina.

NEW YORK: Marty Mann's new book, "New Primer on Alcoholism" was published in September by Rinehart and Co., Inc., The "New Primer" is an up-to-date version of Mrs. Mann's first book," Primer on Alcoholism". Mrs. Mann is Executive Director of the National Council on Alcoholism.

CALIFORNIA: In a recent survey of San Francisco physicians conducted by the Community Health Service Committee of the Health Council of the United Fund, of the 801 doctors who replied, 46% listed alcoholism as the condition which presented the greatest unmet need for services. Copies of the report are available from the United Community Fund of San Francisco, 2015 Steiner Street, at $1 a copy.

GEORGIA: A clinical training program for theological students and ministers is now in effect at the Georgian Clinic in Atlanta. The program, under the supervision of the clinic Chaplain, provides an opportunity for supervised pastoral work with alcoholic patients.

CHICAGO: The July issue of the American Medical Association Journal carries an excellent article on alcoholism, entitled "Robber of Five Million Brains" which discusses alcoholism as a destroyer of manpower. Written by Milton Golin, this article is one of a series entitled "Medicine At Work". In this article Mr. Golin quotes such authorities on alcoholism as the Yale School of Alcohol Studies, the NCA, the WHO, AA, and the Quarterly Journal of Alcohol Studies.

DURHAM, N. C. An Alcoholism Education Program was held on six consecutive Wednesday nights at the Durham YWCA Building, sponsored by the Durham Council on Alcoholism in conjunction with the NCARP. The Program began on September 17, with Dr. Thomas T. Jones, local general practitioner and President of the Council, speaking on "One Drink Away From A Drunk". The last meeting of the session was held on October 22, when Dr. Norbert Kelly, Executive Director of the NCARP, spoke on "Prevention of Alcoholism." The meetings were open to all interested persons and were intended to inform the public as to the nature of alcoholism, how they can help the alcoholic, and the spiritual and psychological aspects of rehabilitation.

In Memoriam

S. KINION PROCTOR

KINION Proctor would have been the first to scoff at any purple passages eulogizing him. He was essentially a modest, unassuming man who didn't want a lot of fuss and feathers kicked up around him. But we cannot fail to express in these pages sincere words of appreciation for his large contribution to the advancement of alcoholism education and rehabilitation.

When Mr. Proctor was called in 1950 to be its first Executive Director, the NCARP existed only as a neatly typewritten legal sized sheet, marked House Bill No. 623. All he had to start with was this law, passed by the Legislature of 1949, giving the State Hospitals Board of Control authority to set up an alcoholism program. It was his task, with the help of the Board to give form and shape to the organization.

He began by "stumping" the state from one end to the other, talking with people. He talked with almost anyone who would listen—doctors, AA's, community leaders, professionals of all descriptions, the man on the street—exchanged ideas and won grass roots support for the Program. Kinion Proctor enjoyed seeing people and talking with them face-to-face. It gave him a chance to flavor his firmly held convictions about alcoholism with some of the Eastern Carolina "folksiness" he absorbed as a son of that region.

The happy result was that out of these persuasive chats grew increasing support and interest for the

(Continued on page 30)

Priest Praises ARP

Dear Sir:

Will you please put my name on the mailing list for "Inventory"? I have studied and helped alcoholics for the past eight years and am delighted to learn of the progressive measures taken by the ARP in North Carolina.

Rev. F. W. McConville, O.M.I.
Fayetteville, N. C.

Help To Business

We feel that "Inventory" will be of great value to us in our organization and would appreciate very much your placing the names of our personnel representatives on your mailing list. Thank you very much.

J. S. Newbold, Personnel Director
Carolina Power and Light Co.
Raleigh, N. C.

Al-Anon Heard From

I am a volunteer worker at the Al-Anon Family Council office in New York City and am also a member of a local Family Group. Your journal has in it a wealth of information of the type we are seeking in order to cope with our problems concerning alcoholics.

Anonymous
Brooklyn, New York

Likes Article

Please place my name on your mailing list for the magazine, "Inventory". Also, I would like to know if the material in this magazine is copyrighted. I recently ran across a page on the mature person that I would like to mimeograph and use in our work here.

Roger J. Westmoreland, Chaplain
Eastern N. C. Tuberculosis
Sanatorium
Wilson, N. C.

One Of The Best

I have been reading "Inventory" and believe it one of the best publications on the subject of alcoholism and wish to say that your whole program is very highly thought of in this community.

Lester W. Lewis
Seattle, Wash.

Studying Alcoholism

Dear Sir:

Please enter my name in the mailing list of the "Inventory" magazine. This fall I shall become a medical student at UNC. I am interested in psychology and social problems. The magazine can help me to become better acquainted with the problem of alcoholism.

Miss Helga Muiznieks
Chapel Hill, N. C.

Church Group Interested

Our Baptist Training Union is studying alcoholism as an illness. I would appreciate your sending me all the literature, pamphlets, brochures, etc., that you think might be helpful to us in this study. We are particularly interested in the church's role in dealing with the problem.

Mrs. Wilma Hall
Rutherfordton, N. C.

VOL. VIII, NO. 3 INVENTORY SEPTEMBER-OCTOBER, 1958

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

Round and round the alcoholic goes and where he'll land nobody knows — but there are a few conjectures.

The Vicious Circle Of Alcoholism

BY VERNELLE FOX, M.D.

Reprinted from GEORGIA LOOKS AT ALCOHOLISM, published by the Georgia Commission on Alcoholism, Atlanta.

ALCOHOLISM is the third major public health problem in the United States today. It is an extremely serious illness, involving some 6,000,000 people in the United States. It is estimated that 65 per cent of the adult population drink and that 6 per cent of that population are alcoholics. Contrary to public opinion, only 15 per cent of these alcoholics are "skid row bums". The remaining 85 per cent are "nice people" —garden variety citizens—typically a 40-year-old white collar worker with a wife and children, member of a church, having a useful place in our society. This is industry's "billion-dollar headache". That's a lot of people with a rather profound and complex illness that is very poorly understood and even less well accepted.

Some of you may remember the difficulties that were present when we began to accept cancer as an ill-

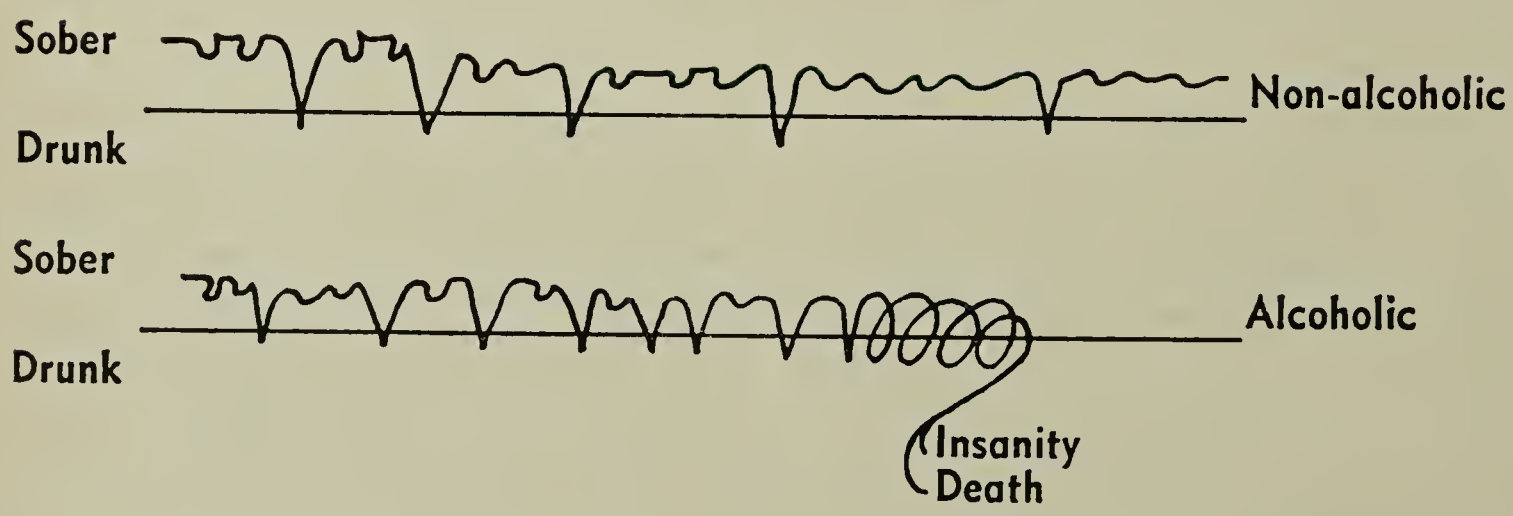
ness rather than as a punishment for our sins. The same thing happened with tuberculosis. In each of those illnesses lay committees were formed whose specific purpose was to modify public opinion, to promote acceptance of the illness, and to help people know that they could help themselves by seeking good care. It took roughly 75 years in each of these illnesses to actually modify public opinion. The first problem is to get people to realize that we are talking about the illness alcoholism—not alcohol. All people have ambivalent feelings about alcohol; it means a great many things to a great many people. We usually see alcohol as pleasurable on one hand and threatening and immoral on the other. These feelings frequently color our discussion of the sick alcoholic.

You read that psychiatry sees the alcoholic as an individual whose basic illness is a question of emotional immaturity—failure to develop emotionally to a mature level; and that this failure of development results in inability to profit by past mistakes, such as the feeling of "Well, next time I can drink without getting into any trouble". This feeling exists even though the facts show that each time, in the last year or two, he has had a drink he wound up in trouble. Then you read what this emotional problem amounts to in terms of religion. The minister says that all of us have our limitations and our abilities and there is a real struggle to balance one against the other; that if one simply ignores one's abilities and accepts only limitations, it's to become a creature among creatures.

On the other hand, if one cannot accept limitations, the realistic feet in the dust that all human beings have, then like the Prodigal Son, he's quite likely to take off into a world of unrealistic acting-out and getting into difficulties. Then at that point if one is exposed to alcohol it is quite easy to find out that alcohol produces a great deal of emotional comfort. It is a mild sedative, it is easily available and it does not have the medical complications of other sedatives—you don't have to have a prescription—just the money to go to the liquor store. As an individual grows to depend on alcohol to ease the pains of emotional life, he is likely to develop physical addiction.

This is where medicine comes into the picture. Physical addiction to alcohol or to any sedative is a clear-cut medical syndrome, with withdrawal symptoms. It is easy enough to say, "Well, just don't take another drink, it is not good for you." Every alcoholic knows it is not good for him, but when he is having withdrawal symptoms it just does not

THE JELLINEK DOODLE



come that easily. Withdrawal modifies not only physical functioning, but mental attitude, with loss of good judgment. The development of addiction to alcohol is a long and drawn-out process. One of the major problems in talking about alcoholism is getting straight the time element. Full blown addiction occurs after an average of ten years of dependent drinking. Dr. Jellinek has studied this whole problem extensively. In explaining the development of the process of alcoholism, he drew what came to be known as the Jellinek doodle which I will borrow and modify a little. (See drawing page 6.)

The line is intoxication or drunkenness—on the bottom you are drunk, on the top you are sober. The average person will drink, will approach intoxication and will usually, sooner or later, become intoxicated. That within itself is no world-shaking event. He may say a couple of things he wishes he had not; and his wife may get a little provoked with him, but still it is not world-shaking. He will usually say, "I am not going to do that anymore," and the next few times he drinks he doesn't. Sooner or later most of us will have a little too much occasionally. That is the so-called normal drinking pattern. It does not change much except that as most of us get a little older, we may quit doing it because we are too old to bother with a hangover.

Same Mechanism

The alcoholics start with the same mechanism. They will be exposed to alcohol and will manage sooner or later to get intoxicated with the usual sort of feelings of "maybe I made a fool of myself last night and I certainly should not do that again"; or, "next time I won't drink so much". They will occasionally manage to drink without getting drunk, but over a period of time they find that they are more and more frequently becoming intoxicated each time they drink and more and more frequently having blackouts. At about this point, most alcoholics recognize that there is something pathological about their drinking and further emotional conflicts begin.

Symbol of Manhood?

Many people feel that being able to "hold your whiskey" is about like being able to shoot Indians, or any other symbol of manhood. We have more stigma attached and deeper mixed feelings about alcohol than any subject, except perhaps sex. So, even though an individual may well recognize that there is something wrong and may honestly want to get some help, this stigma and lack of acceptance may stop him. If he says anything about it someone may reply, "Well, buck up and drink like a man." This just builds up his feeling of isolation and of being "peculiar". He feels he can't talk about it, or look for help, that he won't be accepted or understood anywhere he goes. Gradually, his discomfort increases and the need for alcohol increases and as time goes along he finds he is more and more frequently becoming intoxicated. Then there will be that rare time when he drinks without getting drunk and he is encouraged. "See," he will say, "I am normal, after all. I can drink like everybody else," just as if being able to drink necessarily made him normal.

Gradually the process gets worse and worse in an average of ten years until a point is reached that Dr. Jellinek calls "drinking because of your drinking". The remorse, the feeling of isolation, the feeling of failure from a drinking bout is so great that the alcoholic hardly gets over it until he is so uncomfortable he has to go back to drinking again. He has

developed a way of life around addiction to alcohol. Addiction may manifest itself in one of two ways:

1. Loss of control—that is the spree drinker—each time he takes one drink he will continue until he is drunk and will drink all he can get with no control whatsoever. As a rule he will stop only when his stomach will not take another drink or his source of supply is cut off.

2. Inability to stop—the plateau drinker—he does not get real drunk, but he does not get sober either—he simply cannot stop drinking.

In either case, everything becomes crowded out of the individual's mind and life except how to get the next drink. This becomes complete physical dependence on alcohol and leads to death or insanity, unless the drinking cycle is broken.

If the drinking cycle is broken the individual can do just fine, but he cannot take a drink without getting in difficulty. At this point, you and I and everybody in town recognizes that the individual is an alcoholic and that if he is to get well, he must completely abstain. There is nothing that will enable an individual, regardless of how emotionally secure he becomes, to return to so-called social drinking, but if the individual can become comfortable enough sober he really does not need to drink.

Throughout time, we have attempted in society to get folks to quit drinking by making drinking more uncomfortable. If you stop to think about this thing called motivation, most of us move or do anything in the hope of becoming more comfortable. If you are sitting there with your left leg crossed over your right one you are not likely to move it unless it gets uncomfortable. Why should you? If an individual is uncomfortable sober and knows that alcohol will make him comfortable, naturally his motivation is to take a drink. That goes on within many people every afternoon about five o'clock, the cocktail hour, but it is not a very big push and it does not last very long. Society has tried by law, by moral judgment, by punishment, etc., to make drinking more uncomfortable. Nature contributes with profound illnesses and with difficult inter-personal relations. The more uncomfortable drinking becomes, the more the push is back toward staying sober. This to some degree works, but there is a more humane, and I think probably a more successful way to tackle it; that is to lessen the discomfort of sobriety. If sobriety is an achievement, if sobriety is a pleasant and profitable thing, then there is not so much push towards drinking. These are modern treatment aims.

A HAPPY MAN

IF you observe a really happy man you will find him building a boat, writing a symphony, educating his son, growing double dahlias, or looking for dinosaur eggs in the Gobi desert. He will not be searching for happiness as if it were a collar button that had rolled under the radiator, striving for it as the goal itself. He will become aware that he is happy in the course of living life twenty-four crowded hours each day.

W. Bertram Wolfe
in THOUGHT STARTERS

DOES CULTURE INFLUENCE ALCOHOLISM RATES?

The big question is: "Why do the martini drinkers of Upperville produce more alcoholics per capita than the freely imbibing natives of Sohappiland?

IF you asked a half-dozen people what causes alcoholism you would probably get that many different answers. "Alcohol causes alcoholism," might be the response of an ardent teetotaler. A biochemist would possibly speak of physiological disturbances. A psychiatrist would likely see the problem in terms of personality influences.

While some of your answers would be clearly erroneous, others would contain an element of truth. But none would convey the whole truth. Causes of alcoholism are so intertwined that it is so far impossible to isolate a single cause to explain so complex an illness.

Personality and physiology have come in for a large share of attention in scientists' search for causes of

alcoholism. Now a new area is being searched. Scientists are examining the influences of culture, society and group to see what part they may have in producing alcoholics. In the lingo of the scientist, these are *socio-cultural* influences. Let us think of them more simply as the attitudes, rules of behavior, pressures to conform which have been created by other men and passed on to us as part of our heritage. From birth to death there is constant pressure on members of societies and groups to follow prescribed ways of behaving. Every society, no matter how simply organized, has its own system of unwritten rules. And included among the rules are do's and don't's governing drinking behavior and attitudes toward drinking.

Attitudes Differ

Social scientists have long since discovered that attitudes toward drinking and even the ways in which alcohol is used may differ vastly from one society or group to another. The Lower Sohappilanders, for example, may hold regular feast days when getting drunk and passing out is accepted and even expected behavior. For the Exurbanites of Middle Upperville, on the other hand, anything more than two very dry martinis in public is regarded as highly irregular. But the Sohappilanders may produce few if any alcoholics, while alcoholism may take a high toll among the Exurbanites! Therein lies another interesting observation, namely, that alcoholism rates vary from society to society and from group to group.

What accounts for the variance in alcoholism rates? Scientists are probing for the answer. It is just possible that if they could find out why the drinkers of Upperville produce more alcoholics per capita than the Sohappilanders, they might discover at the same time some new causes of alcoholism. Investigators have been following this track by comparing information on drinking customs and attitudes held in many different societies and groups. Through this process they hope to isolate practices or attitudes which seem invariably related to either high or low alcoholism rate.

Here is the process in a nutshell. Let's say the scientist is comparing a high alcoholism group with a low alcoholism group. He finds that the only thing different about the drinking customs of the two groups is that in the group with few alcoholics the men drink only in the presence of their wives. If on further study, he found that several more low alcoholism groups observed this same practice, he might cautiously deduce that having wives present is a factor in low alcoholism rates. The more instances he found to confirm this, the stronger his case would be. But just one exception—a *high* alcoholism group where wives are present during drinking—and his beautiful theory would be spoiled and he would start to work on another.

Search For Answer

When this type of research was begun it was hoped that some answers to the riddle of differing alcoholism rates could be found in the relatively simple manner described. Some investigators, for example, tried to link *frequency of drinking* with the alcoholism rate. If it could be found that groups using alcoholic beverages more frequently than others also have a higher alcoholism rate, then a cause of alcoholism would have been established. But no such simple relationship could be found. Extensive studies have shown that American Jews, particularly the Orthodox, and Italian-Americans are among those who show extremely low rates

of alcoholism, at the same time imbibing frequently. Thus another theory was scrapped. In a similar way other suspected causes of alcoholism such as *frequency of drunkenness* and *alcoholic content* of the principal beverage have been disproved.

After finding no one-to-one relationships between drinking customs and alcoholism, scientists turned to the more complicated study of culturally produced attitudes toward drinking. They started to ask themselves if certain clusters of attitudes toward drinking exist more frequently in groups with high alcoholism rates than among those with low rates. Here, they are getting some interesting answers.

The best answer that can be advanced at this stage is this: "In any group or society in which drinking customs, meanings attached to drinking, and penalties for violations—together with the attitudes of all segments of the society or group—are well established, known and agreed upon by all, and are consistent with the rest of the culture, the rate of alcoholism will be low." In other words, when drinking customs are understood, controlled and supported by everyone in the group, alcoholism is not a sizeable problem.

Religious Meaning

The perfect example of this situation can be found among Orthodox Jews. Members of this group start using alcohol in childhood, usually in certain religious rituals. They drink frequently, but show little or no drunkenness and an extremely low alcoholism rate. Having been introduced to alcohol at an early age and seeing it used in religious rituals and within the bosom of the family, the Jewish child sees nothing wrong or unusual about using alcoholic beverages.

Similar conditions of consistency in attitudes toward alcohol can be found among Italian-Americans and in the Chinese society. Both these groups, though imbibing frequently, contribute a relatively small percentage of alcoholics.

Now, let's look at a group which contributes a larger than average share to the total alcoholic population. An example is what Selden Bacon has described as the "United States American of the Northeast quarter of the nation—Protestant, middle-class, urban, white, from Anglo Saxon background of three or more generations in this country." The contrast between the drinking customs and attitudes of this group and those of the Jewish group is clearcut.

Varied Answers

Ask members of this group what they think about drinking and you are apt to get rather vague and defensive answers. "It loosens people up and helps get them talking to each other," might be one response. Another might say, "With a few drinks, our crowd can enjoy a smutty story without getting embarrassed." Everybody would have his own idea about the function that drinking serves. Drinking rules and procedures show wide variability, too, depending upon whether the individual is drinking with his family, business associates, whether he is out of town or observing a holiday.

And who has the final word about what is right regarding drinking? Parents? Associates? The ministers? The family physician? In reality, each may be teaching something different about drinking, and, in some cases, practicing still another standard—to the utter confusion of the neophyte. The custom of drinking has no connection with either family or

(Continued on page 31)

Before the alcoholic is ready to surrender, he must "hit bottom." What does this mean and how can the alcoholic's low point be raised?

HITTING

HITTING Bottom is a term often used by Alcoholics Anonymous which means that an alcoholic has sunk just about as low as he can get before he surrenders himself to the AA program. To "hit bottom" means that the alcoholic can no longer stand his way of life; he is confused, frustrated and desperate. Some AA's say that when a man hits bottom, "he doesn't know what to do, where to go, or how to do it." He faces a blank wall. His alibi system has collapsed; he has lost many or all things dear to him and he can see nothing for him but death or insanity. The only thing left to do is to say, "I give up", and with those words, the alcoholic hits bottom.

Not every alcoholic hits the same bottom before joining AA or going into therapy. The term really ought to say, "to hit a personal bottom", because what is the bottom of the ladder to some alcoholics may be only the beginning or middle of the ladder to others. Bottom point for a lawyer, for instance, who becomes an alcoholic will be different from that of a man who has lived most of his years on Skid Row. A housewife's low point will differ from the sophisticated career woman's. A truck driver's will not be the same as a college man's. Yet there is a common denominator for all groups of alcoholics, a "leveler", it is called and that is alcohol and a compulsion to drink it. No matter what social, economic or cultural class alcoholics come from they all share a common problem of excessive and progressive drinking.

To show how one person's experience of hitting bottom may differ from another's, take the case of Jake C.

Jake is a highly successful young insurance man who lives with his wife and three children in one of the nicer suburbs of town. Jake graduated from the State University eight years ago and since that time has enjoyed a profitable profession, a nice social life and has been able to purchase a house a little more expensive than he can afford, two cars, a full-time maid for his wife and membership to the country club. He joined four civic groups for business reasons rather than pleasure and when he's not attending meetings, he spends time on the golf course or at the club with his clients. He sees very little of his family as the children as usually asleep by the time he leaves the office at night and when he finally arrives home, he is too tired to carry on much conversation with his wife.

Jake began drinking a little bit more than usual when he realized how hard he must fight for a living. The competition in town was stiff

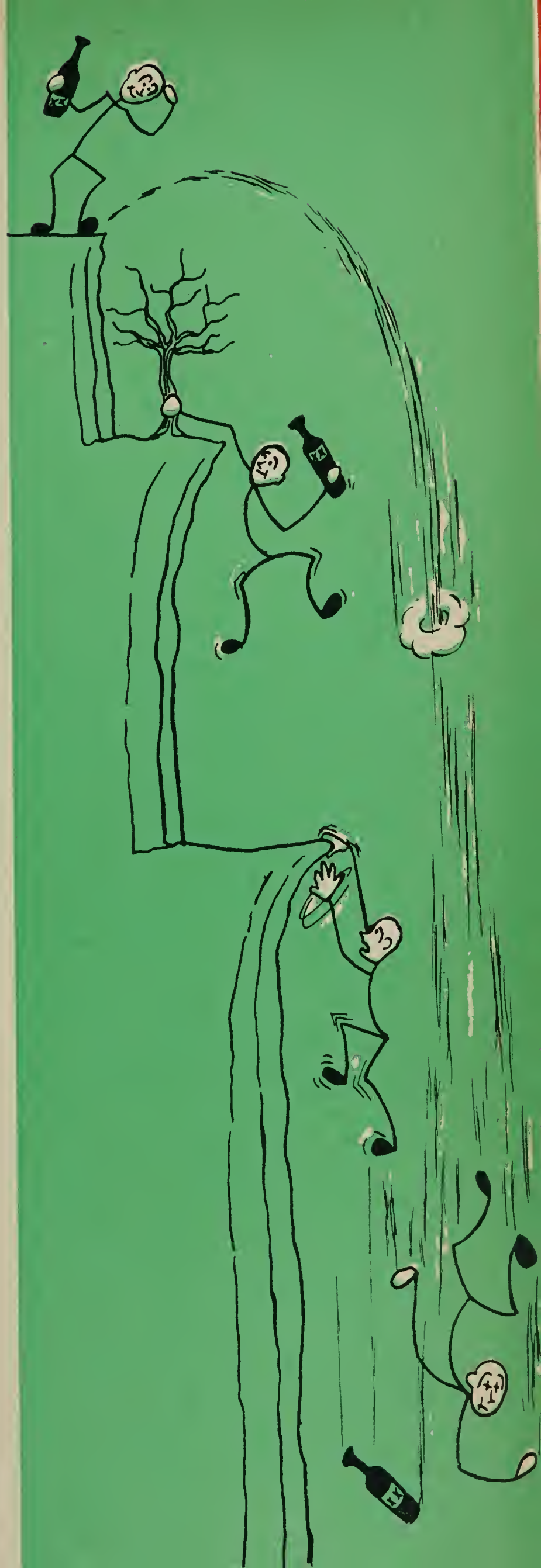
BOTTOM

BY CLAIRE CHENEY

and being new at the insurance business meant he had to really work hard to sell clients in the upper income bracket. Jake was ambitious and he wanted his wife, his home, and all his material possessions to be first quality. If he had to work himself to death to get what he wanted that was all right so long as he was admired, respected and even envied a little by his friends.

A drink would help Jake out before an important meeting with a client. It relaxed him, made him feel more confident and sure of himself. But soon a drink meant more to Jake than just relaxation. It became a necessary booster for his feelings of inferiority and self-doubt. If he sold a good policy, he'd stop in at the neighborhood bar for a few to celebrate. If he lost a client, he'd drink for consolation. Either way, Jake found an excuse for drinking and what was once only a desire for a drink turned into a real need.

Jake sometimes appeared at the office tight or in hangover and was sharply reprimanded by his superiors. Jake, though, ignored their warnings, thinking that he could quit any time he wanted to. One day the director of the company called Jake into his office and asked him to resign. He had received complaints about his drinking and although his record was good, the company could



not afford to keep Jake on any longer.

To Jake, this was bottom. The admiration and respect of his fellow man, to be "top dog", was his main goal in life. When he was fired he saw his prestige, club memberships, social life and material possessions go down the drain. He then realized that he had to do something about his drinking.

Jake went into therapy, learned to modify his ambitions and spent more time relaxing with his family and as the tension and pressure eased up, gained a new perspective of himself. He got another, less demanding job, joined AA, sold his expensive house for one he could more easily afford and to date hasn't had a drink in over two years. It's true that his income has dropped but he no longer feels the need to push himself to the breaking point and he, his wife and children are all happier in their new way of life.

Why Jake Recovered

Jake's bottom point came when his prestige-building job was threatened. At that time, loss of family would not have been so important to him as the loss of his job. His job and making money were the focal points in his life and beating everyone out by turning in more business than his colleagues gave him a satisfaction that could not be duplicated, except in the bottle.

When Jake saw that through the loss of his job he would lose the envy and respect of others that he enjoyed so much, his cars, his fancy home, his parties, the bottle became secondary and he knew he must give it up. But giving up the bottle was not the only answer to Jake's problems. In therapy he learned why he drank too much and through an understanding of his basic personality was able to modify the terrific drive he felt in his work and social life. By joining AA he found others who had similar experiences and with the support he found in them, no longer felt a need for liquor.

For others, though, the bottom point is much further down the scale.

Al F. is a semi-skilled worker in a local machine shop. He married his childhood sweatheart, Jane, and they have six children. Al supports his entire family on his small salary, saving enough out of his paycheck each week to stop for a quick one on the way home from work. When Al failed to show up for dinner several nights in a row, his wife began to worry and questioned him about it. Al became very angry and told her to mind her own business. Soon Al was skipping dinners entirely and often didn't show up at home at all. Since by that time most of his check was going for whiskey, Jane was forced to go to work, a fact she resented and blamed Al for.

Began A Binge

After a violent argument one night when Jane threatened to call the welfare if Al didn't start supporting his family again, Al packed his bags and moved to a cheap hotel, where he got in a supply of whiskey and locked himself in his room. He stayed there over a week and when his money and whiskey ran out, he borrowed from friends and began another bout. He was fired from his job, but managed to find a new one. He worked at this new job for over two weeks without taking a drink, but then one night he stopped in at a beer parlor for only one beer before going home and it was 5 A.M. before the police finally had to take him away for disturbing the peace.

The next few months found Al alternating between new jobs, drinking bouts and a prison cell. After his last arrest, the judge ordered him committed to the State Hospital

which terrified Al because of a deep-seated fear of going insane. He stayed in the hospital 30 days where he received medical and psychiatric treatment. He learned the nature of alcoholism, that it was an illness, not a sign of moral weakness as he had thought, and that he could recover if he wanted to. Members of Alcoholic Anonymous came to talk to him and when they explained their program and told him that they had members who had been even worse off than he, Al decided he would really try to quit drinking. Upon release, he went back to his family, found a new job where the management was interested in alcoholism, and after two relapses in AA steadied on and stayed sober.

Al's Bottom Point

Al's bottom point came when he was admitted to a mental institution and saw possible insanity around the corner. Loss of job, family, friends, money, esteem, self-respect; none of these had the effect on him that hospitalization had. Luckily Al was placed in the hands of understanding doctors who knew how to help him rid himself of his fears. He developed insight into his problems, participated in group discussions about alcoholism and learned to face the fact that liquor to him had made up for what he thought was a wasted life. As a young man, Al had envisoned himself as a happy-go-lucky world traveler who would never be touched by disappointment or mundane responsibilities. His life had turned out quite differently from what he had expected and he felt tied down by his family and experienced guilt feelings because he knew he shouldn't feel resentful. Because of lack of schooling, he was frustrated in his attempts at job promotion and saw himself as spending the rest of his life in a machine shop. At first drinking had only been a pleasant diversion but when he found what it could do for his damaged ego, Al came to rely more and more on alcohol's effects. With a few drinks Al forgot about his family, his job and became the debonair fellow he had always wanted to be. What did it matter if bills weren't paid? Or if his family went hungry or he lost his job?

It is the hope of rehabilitation programs, health agencies and AA to raise the level of the personal bottom point so that alcoholics like Al will not have to lose all material and spiritual possessions before surrendering themselves to those who can help them. If Al's bottom point had come when his family left him or when he was fired from his job, he then would have been spared the humiliation he felt at being in jail and hospitalized. Although it is psychologically necessary for each alcoholic to reach bottom before he is willing to seek help, if the alcoholic is fully aware of the warning symptoms of alcoholism, he might seek help before he becomes so emotionally and physically entangled that he can see no way out.

A Basic Change

Early detection and treatment, however, are dependent on more than just knowing the early signs of alcoholism. What needs to be done is a basic changing of society's attitudes towards alcoholism and the alcoholic. Even if a problem drinker knows by heart all the warning symptoms of this illness, it is another thing for him to be able to translate those symptoms in terms of his own drinking.

It would seem then that raising the alcoholic's bottom point is a job for education, and not just educating people to the warning symptoms, but helping them realize that alcoholism is not a moral problem, but a social

problem. In spite of everything being written about this illness, many do not believe that alcoholism is a compulsion and a sickness. This lack of acceptance of the sickness conception is often even held by the alcoholic himself, and so long as the alcoholic thinks of his trouble as a matter of weak morals or will power, he will not seek help. Who wants to admit that they are weak and corrupt?

Rehabilitation programs, such as the ARP, are incorporating more and more preventive measures into their educational programs as one way of raising the level of the alcoholic's personal bottom. Listen to any AA speaker and you'll hear how he or she hit bottom before they came to AA. Mental Hygiene Clinics and Treatment Centers often refer to a patient's bottom point and the need for it before the alcoholic can be helped. Since it is obvious that the alcoholic must hit bottom, it is the job of everyone working in the field of alcoholism to see that the bottom point is raised.

Churches, physicians, teachers, professional men and women in the field, all have an educational job to do. Until the sickness conception is held by alcoholics and the general public alike, very little can be done to help the alcoholic hit bottom during the early stages of his illness. In order for the alcoholic to admit that he is sick, the community will have to be motivated towards early detection and treatment of alcoholism. The obstacles to treatment will have to be removed from the mind of the alcoholic himself. The alcoholic will have to know that he will be accepted and welcomed back into society after treatment and there will have to be sufficient treatment facilities for treating alcoholics. But before treatment can be successful on any widespread scale, the public must be educated to accept excessive, compulsive drinking as an illness and must then be given the facts of the illness. Perhaps one day through education and the availability and acceptance of treatment, the standard bottom point for all problem drinkers will come when they find themselves on what is now considered only the first step to alcoholism.

JAMES W. MURDOCH, M.D.

For the second time in little more than a month, death has claimed one of our leaders. Dr. James W. Murdoch, General Superintendent of the N. C. Hospitals Board of Control, and the NCARP's immediate superior, died September 16 in Memorial Hospital, Chapel Hill, of a stroke. He had been in declining health for some time.

Dr. Murdoch came to North Carolina from England in 1947, to become Superintendent of State Hospital at Butner, remaining there until 1955, when he was appointed to head the entire State Hospitals system. He instituted notable improvements in the care of the state's emotionally ill patients, establishing a sound reputation for good management and progressive treatment methods. In his dealings with the NCARP, he had always been sympathetic and helpful.

The ARP staff extends sincere sympathy to Dr. Murdoch's family and to those close associates who feel his loss most keenly.

WHO IS THE PROBLEM DRINKER?

What do the jargon words really tell us about the alcoholic?

WHO is the problem drinker? How can he be recognized? And how, if possible, can he be singled out before his symptom has overwhelmed him? Is there, in short, any particular personality type that is uniquely characteristic of the alcoholic?

There have been dozens of attempts to establish a clear and specific picture of the alcoholic personality and, by far the more difficult job, of the pre-alcoholic personality. The fair-minded reader who sets out to analyze an appreciable number of the reports of these attempts will come away with two conflicting impressions.

On the one hand, the investigators vie with each other in denying that there is such a thing as the alcoholic or pre-alcoholic personality. The more they test or diagnose, the more convinced they are (or remain) that the alcoholic is as various as man. And man, if he is nothing else, is various.

They describe him in many terms. They attribute to him many characteristics. These will include low self-esteem, self-pity, a tendancy to self-punish, resentment, a disposition to project the blame for his troubles to other people (his boss, his wife, his mother, and so on), a readiness to deny his illness, impatience, tension, depression, volatility of mood swings, stubbornness, anxiety, jealousy, and so on and on an on. Their list encompasses nearly every emotion and personality trait available to man.

On the other hand, with something close to unanimity, the investigators report the same salient personality traits. They may use different words to describe these traits, as why should they not, but nonetheless the same ones keep cropping up, no matter what the techniques used to uncover them. To use the words most often chosen to describe these traits, they are: *egocentricity, low tolerance for tension, dependency,* and *feeling of or longing for omnipotence.*

These are jargon words, and so it will be useful to talk about each of them in more detail.

Egocentricity describes the set of mind in which most of one's concern is with one's own needs and pleasures. The concerns of others are largely a matter of indifference to the egocentric. He seeks the center of the stage; the first person singular

pronoun rattles through his speech like drum taps. Psychoanalytically, the term for egocentricity is narcissism, adapted by Freud from the Greek myth of the beautiful youth Narcissus who fell in love with his own reflection in the water (and died, still pining, condemned by the gods for his cruel foolishness in declining to give others his love). We are all more or less narcissistic, in the sense that all of us basically love ourselves more than any other. And there was a time in our lives when this self-love was natural, normal and necessary: the stage of primary narcissism is placed in early infancy; it coincides with the period during which a baby does not recognize and distinguish himself from the objects or the people offering him gratification; for him, during this period, reality is only the recognition of his need and its gratification. His instinctual impulses are directed solely toward himself.

Character Traits

Low tolerance for tension is the character trait perhaps most often mentioned in connection with alcoholics. Stimulus and reaction are so closely interwoven, with the alcoholic, that they are practically one thing. Resentment, anger, hostility, rage, anxiety, frustration, mild apprehension, or sudden and overwhelming fury—anything that creates tension is the Achilles' heel of the alcoholic. The tension can come from some trivial occurrence of everyday life, or it can well up from some deep-seated psychic conflict, it makes no difference, the alcoholic personality is not gaited to withstand it. He is impatient. He is intolerant of his own moods and those of others. He demands that things go smoothly. If they do not, when they do not, he reacts immediately. His reaction is as swift as that of the baby who awakens hungry, experiencing tension. Like the baby, he is at once caught up in a squall.

Dependency, as a trait, is likewise regressive. There is nothing morally wrong with regression; we all do it: sleep is a kind of regression, a return, however fleeting, to a time when we were fully cared for and protected, and needed not fend for ourselves. No mammal is more helpless than the human during its infancy; and any situation that threatens the individual may well remind him of how, when he was a wholly dependent infant, all was well. The dependent individual will, for unconscious reasons, always seek to be taken care of: he may contrive his marriage to a strong, maternal woman; he may wangle jobs in which he can depend in some way on the one who hired him; in any life situation he may so act as to seem to deserve the care and concern and regard of others.

Grandiosity

And finally there is the feeling of omnipotence. This trait, too, is almost universally reported by the psychiatrists and psychologists who have sought to establish *the* alcoholic personality. (Sometimes they call it grandiosity.) We have encountered this concept before, when we were discussing the psychic and unconscious factors that impel us to drink, but in its more pronounced form as an alcoholic trait it demands further discussion.

Why should someone who is quite obviously damaging himself, poisoning the regard of all those around him, undermining health, career, and future—why should someone in such a plight feel omnipotent? How can it be that a man enslaved to a drug addiction can be so blind? And yet it is the case. It has puzzled every therapist in the field. Years ago, Sandor Rado wrote: "I must admit

. . . I could not grasp the economics of this state of mind until a patient himself gave me the explanation. He said: 'I know all the things that people say when they upbraid me. But, mark my words, doctor, *nothing* can happen to *me*.' This, then, is the patient's position. The elation has reactivated his narcissistic belief in his *invulnerability,* and all of his better insight and all of his sense of guilt are shattered on this bulwark."

The same mental attitude was described in the same terms by Harry M. Tiebout, who wrote: "(It) is . . . difficult to put one's finger on. It may be described as a peculiar unconscious sense of invulnerability. The patients create the impression that the disaster, however threatening, cannot affect them. They are psychically untouched by danger. While consciously troubled, they have a serene unconscious belief in their own survival; they just cannot be licked."

Four Main Traits

Egocentricity; low tolerance for tension; dependency; and a sense of omnipotence: These four traits share two things in common: each is a vestigial trace of infancy and each is, presuming a relative degree of intensity, neurotic.

There is in every one of us, without exception, some trace of each of these traits. It is the combination of two or more of them, grossly intensified, that predisposes some of us toward the selection of alcoholism as the particular symptom.

There is of course no law that decrees these traits shall be confined to any one given personality type. On the contrary, the laws of probability are overwhelmingly against such a conclusion. For consider: since all four date from early infancy, there will be overlaid upon them the experiences of a consequent childhood, puberty, and adolescence, each experience coloring, affecting, and changing the earliest mental conceptions. The adult personality is the sum of them all.

A myriad experiences and impressions crowd in upon us every day of our lives; chance, wholly capricious, may well determine how we receive them, how we react to them, which of them we receive—in short, which may be meaningful to the ego structure. The infant in whom two or three or four of these four traits will be marked may be an only child, he may be one of twelve; his parents may be poor and obscure, they may be wealthy or celebrated; he may grow up rebellious or conformist, placid or volatile, impetuous or lazy, brilliant or dull. Select your own adjectives, construct your own basic personality: it makes little difference —whatever it be, there is the chance that the constellation of pre-alcoholic traits may figure in it, and may come to grow in intensity so as eventually to overwhelm it.

A Delicate Balance

In this connection, it cannot be too imperiously urged that the process of alcoholism as a neurotic symptom is dynamic. Nothing could be more erroneous than to visualize the four underlying traits of the pre-alcoholic personality as being always in safe abeyance for most drinkers and always in riotous command over a few others. The factors of life are always in delicate balance. It is not impossible to conceive of an individual whose early life would seem to have predetermined him to alcoholism, but who nevertheless at no time encountered precisely the intricately interwoven set of circumstances that would have proven, for him, fatal. Just so, it is likewise reasonable to suppose that many alcoholics would not be in the grip of their neurosis were it not for

some situation that ravaged the strength of their ego structure.

Everything in life is in flux. Change is the only constant. The young man or woman of, say, twenty-two, who today does not let that day go by in which he (or she) orders at least two drinks, may tomorrow be an alcoholic or a teetotaler—and chance will play an important part in the drama.

We have said that the choice of symptom, the nudge in the direction of alcoholism, results from the intensification of two or more of the predisposing pre-alcoholic traits. Now we have added that all is chance, that those traits may be in the process of growth or of decline. The question may be fairly put: what will tend to strengthen such traits? and what weaken them?

Suggestive Evidence

It is a matter of common observation that many alcoholics come from families in which there is at least one relative who is also an alcoholic. This has, in turn, fostered the notion that alcoholism is hereditary. Something like sixty to seventy per cent of alcoholic patients report near relatives who were alcoholics. It is suggestive. But the evidence, the carefully assayed evidence, indicates that it is an environmental influence, not an inherited taint, that tilts the individual in the direction of alcoholism. Ann Rowe studied thirty-six children who had been removed from their own homes by court order because of severe alcoholism in one or both parents. The children, when they were placed in foster homes, averaged five-and-one-half years of age. Twenty-seven years later, these children had attained a general adult adjustment and overall personality development comparable to that of the general population. Not one was an alcoholic.

But if heredity is not a factor, certainly environment is, as are also the social pressures to which the individual must adjust. There are some, indeed, who hold that such social pressures may be determinant in causing a neurosis. But it is more likely that the neurosis, the collapse of mental and emotional balances, the subversion in the healthy development of the ego, occurred archaically in the life of the individual, or was at the very least first initiated at that time. The role of social pressures, however, and of environment in general, can by no means be underestimated; what one's father habitually does, or what is socially approved and urged, becomes a component of the superego; and so it is possible that the act of drinking, even the act of drinking to excess habitually, may at the same time bring instinctual gratification and satisfy the superego. And what, after all, is character, if it is not the ego's adjustment to the demands of the external world, the instincts, and the superego?

Exogenous Factors

There are, additionally, exogenous factors that can influence the individual to drink excessively, and even to drink in the direction of an addiction. Physical pain is one such; alcohol's analgesic property can be exploited to induce, in a theretofore reasonably well adjusted personality, a tendency toward addiction. Remove the external stimulus, end the pain—arthritis, neuritis, whatever it may be—and the mature strength of the ego will once again be sufficient to meet the threat of encroachment by any or all of the predisposing traits.

But the most important factor, the one which is more powerful than any other in strengthening these traits and, indeed, in enabling them to crowd all other traits into the back-

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COUGHING AND ALCOHOLISM

A Legend And Some Suggestions

BY JOHN A. EWING, M.D., D.P.M.

● *An analogy of symptoms, written by a leading psychiatrist*

ONCE upon a time in a far off land a king and his ministers decided that there was too much coughing among the citizens. Nearly everybody coughed sometimes, but some people coughed nearly all of the time. Some of the latter could not work, their families suffered and they set a bad example. Putting severe coughers in jail did no good, and anyway there were not enough jails.

The king and his legislators decreed that there should be a special Coughing Rehabilitation Program. This was set up at once and people were told why coughing was bad for them and were given a lot of advice. Those who had the problem badly enough entered a Coughing Rehabilitation Center. Such serious cases had often tried lots of other measures—staying away from other coughers;

seeking spiritual guidance; taking medicine to suppress coughing.

At the special rehabilitation center there were doctors who were supposed to be experts in coughing. They used treatments to the best of their abilities but many patients still coughed after they left the treatment center.

So the doctors asked the king and his ministers for money for research. They wanted to find out the cause of coughing and to compare different treatment methods scientifically.

"No", said the king and his ministers, "We want results, not theory. Treat the coughs and never mind *why* people cough."

Analogy of Symptoms

The reason I chose coughing in the above fable is that I have found it a useful analogy in talking about the symptomatic nature of alcoholism to groups of lay people. Coughing, like alcoholism, is a symptom. There are over 30 causes of coughing and nobody with a cough of any duration would be satisfied if his doctor only gave him medicine. If the cough persists the patient expects the doctor to search for the basic cause. This means examination of the chest, X-rays, laboratory studies, even hospitalization—no stone must be left unturned. While coughing itself is rarely a threat to life it can be the symptom of a serious disease although, of course, it is usually only the transient symptom of a minor disease.

If doctors were satisfied merely to treat the symptom in their patients they could relatively easily suppress the cough of most patients. Powerful medicines are available which will stop coughing and the doctor may well use these (to enable a patient to sleep at nighttime, for example). However, to continue to suppress the cough and to ignore the fact that *something is causing the cough* is to give the underlying disease a chance to continue undisturbed. The doctor's program, therefore, is to discover the cause and to treat that. He is never satisfied just to treat the cough alone unless it is merely the brief accompanying symptom of a minor thing like a cold.

Alcoholism too can be suppressed if heroic measures are taken against it. Placing an alcoholic patient in jail or in the hospital frequently forces him to stay sober (although I have known him to obtain alcohol even there.) Taking antabuse is another approach which makes drinking *almost* impossible, at least until the antabuse is out of the system. However, approaches such as these are dealing merely with the *symptom* of alcoholism and completely ignoring the person who is suffering from this problem. While those of us who work with patients suffering from alcoholism are beginning to learn a great deal about the problem, and about the people who have this problem, it would be wrong to suggest that basic research is no longer required. I can readily state that alcoholism appears to me to be a symptom of underlying emotional maladjustment. However, I believe that a great deal more basic work has to be done in studying the causation of alcoholism and in comparing various treatment methods, etc. In this respect the North Carolina State Legislature is like the king and his ministers who said, "Never mind the theory. It doesn't matter what causes the symptom—just get on with the treatment."

Of course, such an approach is obviously short-sighted and should be corrected. We still do not know the cause of cancer, but we *can* treat cancer when it has developed, with remarkably good results. In spite of this fact vast sums of money are presently being poured into cancer

research. It is obviously desirable to find better ways of treating cancer, and eventually to find a way of cancer prevention. Only the concerted efforts of hundreds, if not thousands, of scientists led to the successful drive against polio, culminating in the development of the preventive Salk vaccine.

I do not wish to hold out the hope that a preventive vaccine can be developed for alcoholism, but I do believe that we can greatly improve our treatment methods. We can learn to treat alcoholism at much earlier stages than at present, and we can do a great deal in the area of prevention, finally.

Appeal To Legislature

Everyone who reads this is in a position to influence his state Representatives and Senator who will be meeting next in 1959 and who will then once again have a chance to correct their error of the past by allocating funds, not just to alcoholic rehabilitation, but also to basic research into the causation of alcoholism. Such funds should be made available to be allocated by a committee of professional people who are suitably trained to evaluate the application of scientists for research grants. Such a committee, if taking a truly long-term point of view, would allocate the funds to basic research which might at first appear to be relatively remote from the problem of developed alcoholism. Other research would be more obviously alcoholism-connected, and even involved in studies of the treatment methods of alcoholism presently in use.

Financial assistance for research in alcoholism in available in greater or lesser amount in many places, although not presently as part of the North Carolina Alcoholic Rehabilitation Program. In spite of this fact North Carolina is by no means last among the states when it comes to actual research in the field of alcoholism presently going on. This research, be it noted, *is in spite of the lack of funds*. It is being carried out mostly by physicians, and almost exclusively in University centers.

I have before me the current list of research in the area of alcoholism which is known to be going on throughout the United States and Canada. I have analyzed this and will present this data in two tables. Actual research is only recorded in 21 States and Provinces of Canada, 15 projects being known to be in progress. Table I lists this by State and Province. We can be proud to see that North Carolina is ahead of many other states.

TABLE I: Numbers of Research Projects About Alcoholism Known to be in Progress in U. S. and Canada

STATES AND PROVINCES	
Alberta	2
California	13
Ohio	7
Connecticut	3
Georgia	2
Kansas	7
Louisiana	1
Montana	1
Massachusetts	12
Michigan	3
Minnesota	1
New Hampshire	3
New Jersey	1
New York	9
North Carolina	7
Ontario	20
Oregon	1
Pennsylvania	4
Rhode Island	2
Texas	5
Virginia	11
Total	115

Table II lists these 115 projects according to the type of study involved. The classification is my own, accord-

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Rockingham County Committee On Alcoholism

A determined lady, with the help of interested citizens, proves it is possible for a community of even modest size to have an alcoholism program that works.

IN January of this year, another county in North Carolina joined in the fight against alcoholism when the new office of the Rockingham County Committee on Alcoholism opened in Reidsville. Reidsville, located just west of the Piedmont Section of the State, is essentially a farming community. Its population is small yet two years ago, there were enough doctors, ministers, lawyers, pharmacists and laymen in the town who recognized the community's responsibility to the alcoholic to establish a local alcoholism information center: a place where alcoholics and their families and friends could find information about treatment facilities in the State, secure counseling services and educational materials about alcoholism.

The Rockingham County Committee on Alcoholism was officially chartered by the State of North Carolina on August 14, 1956. Most of the credit for the formation of this Committee was due to the perseverance of Mrs. Anne Wall, a Reidsville housewife who years ago became interested in the problem and since that time has worked for and with the alcoholic and his family. Mrs. Wall is now Executive Director of the Committee.

Until January, the Committee had worked without an assured budget. But this year they were accepted by the United Fund as members and $2000 was raised for the program, the first budget the Committee has had. Heretofore they had operated on money from gifts and donations.

The Committee's new office, located in the County Office Building, was donated rent-free by the Rockingham County Commissioners. Mrs. Wall's desk was given by Judge Susie Sharpe. A chair was donated by an anonymous merchant.

Office hours for the Committee are from 1:00 until 5:00 five days a week,

but anyone needing help immediately is welcome at any time and is not limited to the set office hours.

The basic principles of the Committee are the same as most local alcoholism programs. (1) Alcoholism is a disease. (2) The alcoholic can be helped and is worth helping and (3) Alcoholism is a community problem and therefore a public responsibility. The job of the Committee is to educate their citizens to the problem alcoholism presents to a community, to provide a liaison between the alcoholic and treatment and to act as support for the alcoholic and his family. But their services are not restricted to alcoholics alone.

"I don't want people to think that no one but alcoholics can come in here," says Mrs. Wall. "We have a coffee pot going and visitors are welcome. We want people to know about us. Any group or person who comes into contact with alcoholics or who has an alcoholic problem can use our aid. It is free. There are no charges for any of our services."

The Rockingham County Committee is not concerned with the wet-dry dispute. It takes no stand on any controversial issue. The office was set up to lend aid to alcoholics and to increase public understanding of the illness. Part of the activities of the office are to help coordinate existing facilities for the rehabilitation of the alcoholic and to provide an information center where anyone may secure information about the illness. Last year, even without a budget, the Committee sponsored six classes on alcoholism, sent twelve men and one woman to rehabilitation centers and spent 120 hours of personal counselling.

"This year we hope to double, triple the work we did last year," says Mrs. Wall.

When asked to give a summary of the work done by the Committee,

Mrs. Anne Wall, Committee's founder and Executive Secretary.

Dr. Sam Stallard, Medical Advisor and member of the Advisory Board.

Mr. Hunter Gammon (above), Treasurer and local pharmacist. (Right) Mr. Angus Wicker, President of Advisory Board.

Mrs. Wall said, "There is no quick way to sum up the activities of the office, since I believe that we are one of the few Committees that go into as many phases of the work. We arrange within our budget food, lodging, medical aid, family aid and counselling. We make all arrangements for men seeking treatment, working in close cooperation with all facilities within the State and County. We go into the homes when called, regardless of the time or the financial status of the people calling on us.

"This office prepares case histories for the Alcoholic Rehabilitation Center at Butner and any agencies which request them. We also follow up each case on his return from a treatment

The long-range goal of the Rockingham County Committee is to set up in Reidsville a local treatment center. Plans are now in the making for the presentation of this proposal to the County Commissioners.

The Committee hopes that as more people hear about their current program and future plans for the treatment center, it will be seen what an important part a local information center plays in the rehabilitation of the alcoholic and tax support will be forthcoming. Says Mrs. Wall, "We still need more funds to reach all the communities in the county, but I have a definite conviction that each year will see more people become interested in our program and through them, more aid will become available."

TAKE YOUR CHOICE

BY DR. KARL MENNINGER

To me it is a strange and dismal thing that in a world of such need, such opportunity and such variety as ours, the search for an illusory peace of mind should be zealously pursued and defended, while truth goes languishing.

Unrest of spirit is a mark of life; one problem after another presents itself and in the solving of them we can find our greatest pleasure. The continuous encounter with continually changing conditions is the very substance of living. From an acute awareness of the surging effort we have the periodic relief of seeing one task finished and another begun, and the comfort of momentary rest and nightly sleep.

But a querulous search for a premature, permanent "peace" seems to me a thinly disguised wish to die. As I have said elsewhere, in paraphrase of Freud, man is a creature dominated by an instinct in the direction of death, but he is also blessed with an opposing instinct which battles heroically with varying success against its ultimate conqueror. This magnificent drama of conflict sets us our highest ideal—spiritual nobility and social achievement.

For most people in this rugged world, the problems of reality are sufficient in power and prevalence to preclude all complacency. But for many others it is not the problems of reality or the problems of other people which most disturb peace of mind; it is lovelessness.

Their cry for peace is a cry for unearned love, in the face of the wisdom of Jesus and Lao Tse and many others who taught that we get love only by giving it.

To seek after peace of mind is to forsake this truth for an illusion. It is the search to which I object, because striving for personal peace means turning one's back on humanity and its suffering, losing one's life in trying to save it.

On the other hand, peace or something near it is often achieved by those who do not seek it, who, seeking truth, forget themselves.

AA

Dictionary of Terms

Through the years AA's have developed their own special language. Here are a few often-used terms

alky—an alcoholic

Big Book—the "Bible" of AA—**Alcoholics Anonymous**

bounces—relapses from sobriety

Chip—a cardboard chip that is given to AA's on certain anniversaries of sobriety.

civilian—a non-alcoholic

horrors—delirium tremens

dry-drunk—an alcoholic who no longer drinks, but who has not found peace or serenity.

laughing academy—a mental hospital

lone-wolf—a solitary drinker

loner—an AA who is separated geographically from a group, but who still follows AA

monkey juice—cheap wine or Sneaky Pete

moral inventory—a listing and/or evaluation of one's moral practices and ideals

pigeon—a newcomer to AA

pilling—taking pills along with or instead of alcohol

prospect—an alcoholic who is ripe for membership into AA

regular—the compulsive use and need of alcohol every day

rug or silk-stocking group—the "country-club" type of AA group

skull jockey or brainwasher—a psychiatrist

slips around or slips—a relapse from sobriety

sponsor—one who initiates an alcoholic in AA and becomes a benefactor for him

stinking-thinking—a state of mental confusion or a clinging to resentments, failures and self-pity

Forgiveness or condemnation?

Presented to us are

2 WAYS of responding to guilt

BY WILLIAM ECKHARDT, M.A.

AFTER Jesus was arrested, Peter followed him but denied his master three times. "And immediately, while he was speaking, the cock crew. The Lord turned his head and looked straight at Peter, into whose mind flashed the words that the Lord had said to him: 'You will disown me three times before the cock crows today.' And he went outside and wept bitterly."

"Then Judas, who had betrayed him, saw that he was condemned and in his remorse returned the thirty silver coins to the chief priests and elders, with the words, 'I was wrong—I have betrayed an innocent man to death.' And Judas flung down the silver in the Temple and went outside and hanged himself."

Peter and Judas were both guilty. Peter was a liar and a coward. Judas was an informer and disbeliever. He thought his master was crazy to place such a high value upon forgiveness as a means to eternal life. They both admitted their guilt, but they responded to guilt in different ways.

Peter, a rough, uneducated fisherman, failed to understand many of the fine points in the parables. He often became anxious and faltering in his faith. But in spite of his doubts and uncertainties, he was convinced that Jesus' method of forgiveness had tremendous healing power. He believed that the gospel of forgiveness was a far better way of ruling people than the law of retaliation. When he found himself guilty, he "wept bitterly"—but he went on living by the grace of his faith in forgiveness. He went on living and established the first Christian Church in the heart of those who believed he worshipped a mad master.

Judas, a clever, sophisticated fellow, was apparently disappointed when he found that Jesus intended to conquer Jerusalem by love alone. Blinded by sophistication, he could not help believing that his master must be mad indeed. So he informed the chief priests of this fact, without which they could not have touched Jesus. When he found himself guilty, he "hanged himself." He could not believe in the power of forgiveness to save his life. He proved by his death that life cannot go on without forgiveness.

There are two ways of responding to guilt. The way of life and the way of death. Our life does not depend upon whether we are innocent or

guilty. We are all guilty, there is no doubt about that. Our life, our health and our happiness depend upon our *response* to guilt. Either we punish ourselves *or* we accept forgiveness. Punishment and condemnation lead to sickness and death. Without forgiveness, we cannot go on living.

Given the pattern of guilt and punishment, our life is arrested. Harsh judges that we are, we sentence our life to prison. We close the door on life and refuse to go on living, we think so badly of ourselves. We think we deserve to rot and die. We think it serves us right. We pay the penalty with pride. Pride and punishment block the life force, and keep life from going on. They keep us from getting on with our life.

Science, especially modern psychiatry, has discovered the fallacy of punishment and the truth of forgiveness. These scientific discoveries are remarkably similar to those of St. Paul who was well acquainted with and well instructed in both these ways of responding to guilt. Paul found through his own experience that punishment led to death while forgiveness led to life.

The evidence is insufficient from a narrow-minded definition of science, but since the issue is of immediate importance to those who are seeking the way of life, some tentative conclusions may be drawn from the clinical evidence at hand.

Both of these patterns seem to be implanted in the minds of all of us. No one is predestined one way or the other, except that our childhood and early life experiences are likely to predispose us to believe in one way more than the other, and consequently to invest more of our energy in one or the other of these two patterns.

The more energy we spend in judging and condemning ourselves, the less energy is available for accepting forgiveness. The more energy we spend on forgiveness, the less we can punish ourselves. The energy spent on forgiveness is well invested, returning interest as high as ten thousand per cent (a hundredfold). The energy spent on self-punishment is badly invested, returning no interest and taking away even the original energy invested.

The distribution of energy depends on how much we value humility and forgiveness relative to pride and punishment. Whoever teaches us to punish ourselves is showing us the way to death. Whoever teaches us the value of forgiveness is showing us the way to life. Teachers have a responsibility, but learners beyond a certain age also have a responsibility. No matter what is taught, the person who learns to punish himself is killing himself. And whoever learns to accept forgiveness is learning how to live and that abundantly.

Confronted with their guilt, Judas punishes himself but Peter accepted forgiveness. The one went to his death, the other to his life of founding a church to glorify God, to teach others the value of forgiveness and to save himself in the process.

By the same processes of self-punishment or forgiveness for guilt, you and I are either destroying or saving our lives. We are either judging ourselves and others by the standards of human pride, or we are loving ourselves and others in spite of our sin and guilt. The patterns, as such, do not determine our destiny. We determine our destiny, one day at a time, according as we distribute our energy more to one pattern or the other. Do not waste precious time and energy trying to change the patterns. Just invest your energy *now* in the pattern of forgiveness if you want to get on with your life.

S. Kinion Proctor

(Continued from page 3)

state's new alcoholism program. Many of today's staunchest supporters of the NCARP were won over by Mr. Proctor in those early days. Just the other day, we were talking with a distinguished North Carolina physician who has been a tower of strength in the fight against alcoholism. "Kinion Proctor came to see me one day," he said, "and got me interested in this alcoholism business." Others in many walks of life could offer similar testimony.

Under Mr. Proctor's guiding hand, the NCARP passed milestones in its development at a steady clip. The new treatment center at Butner opened its doors and admitted its first patient. The education program was launched with the appointment of an education-information director. Out-patient alcoholism services were arranged with the Mental Hygiene Clinics. First copies of INVENTORY rolled off the press and were eagerly snapped up. Voluntary requests for subscriptions began to pour in as did requests for speakers and other information services. Summer Schools for teachers were instituted. So it was that what began as a "paper" program on alcoholism unfolded and grew as Mr. Proctor applied his energies to the task.

No one was more elated at these developments than Mr. Proctor, for he invested a large share of himself in the organization he headed. When it progressed smoothly he was on top of the world. When obstacles arose, he was not happy until they were circumvented. It is completely in character that his one expressed complaint during his fatal illness was, "I don't know what is going on at the office."

Now, eight years later, tangible results of his leadership can be seen on every hand. The state's people have responded enthusiastically to the ARP educational message. More than 2,800 alcoholic patients have voluntarily received treatment at Butner. Better than 75 per cent of general hospitals in the state now admit alcoholics for medical treatment, a complete reversal of the situation at the NCARP's inception. Several hundred classroom teachers, through the ARP's summer studies are better prepared to fulfill state law requiring facts about alcohol to be taught in the public schools. Other professionals—physicians, ministers, social workers, nurses—as well as laymen have been given a new understanding of the alcoholic.

He earned recognition for the Program and for himself beyond the borders of North Carolina. Since 1949, Mr. Proctor has taken part in regional and national meetings of agencies dealing with alcoholism and related problems, and was regularly invited to appear as consultant at the Yale Summer School of Alcohol Studies. He drew particular pleasure from his affiliation with the North American Association of Alcoholism Programs, an organization which he helped to found and later served as Secretary-Treasurer and, at his death, as executive committee member.

Indeed, Kinion Proctor deserves to be remembered for his many achievements. And we who were his close associates join a grateful state in paying tribute to him for what he did. But we will remember him, too, for the man he was. When Mr. Proctor died on August 12, he left behind a group of friends and fellow workers who will always remember him affectionately as a kind, considerate man of good will. And, leaving aside all his wonderful attainments, these lingering sentiments shared by many, form perhaps the most enduring monument after all.—GHA

Culture and Alcoholism Rates

(Continued from page 11)

religious institutions as it does in the Jewish and Italian groups.

The result of all this is that the group member who starts to drink usually does so with great emotional conflict and feeling. He may feel guilty, or angry, or exhibitionistic, or secretive. This is what happens, says the social scientist when drinking customs are not clear-cut, understood and agreed upon by everyone in the group. This situation, they believe is related to a higher than average alcoholism rate.

Study of other high alcoholism groups, including the Irish-Americans, tends to bear out this sociocultural theory, However, the scientists are first to caution that they have not arrived at any final answers. Much more data must be collected, sifted and studied before these ideas become conclusive. Nevertheless, they do point the way to a new and fascinating research area in the continuing effort to find answers to this age-old problem.

Who Is the Problem Drinker?

(Continued from page 20)

ground and completely dominate the personality, is the pharmacological property of the drug itself. The predisposing traits urge the individual to the use of alcohol, alcohol emphasizes and enhances the traits themselves, and so the individual has recurrent recourse to the magical substance. The cycle is now closed, and it is vicious indeed. It is a cyclical regime which, unless it can be interrupted, will lead inexorably to addiction, severe physical and psychical damage, and death.

Coughing and Alcoholism

(Continued from page 23)

ing to the description of the studies as given by the investigators. In nine cases the description was vague in some respect so that I had to leave the study "unclassified". Looking at this table leaves me with the feeling that research into alcoholism is in a pretty healthy state throughout America. I do feel that increased study in the medical and psychiatric areas is called for as well as more work by sociologists and psychologists. Larger numbers of follow-up studies are really needed, and there is certainly no area in which it could be said too much work is being done.

TABLE II: Types of Research into Alcoholism Known to be in Progress in 115 Studies

Laboratory: Pharmacology, Metabolism, Biochemistry, Endocrine, Animal Experiments, Medical Effects	34
School teaching about alcoholism	3
Hospital studies, medical studies, neurological, psychiatric	15
Sociological	12
Drug Studies	7
Other treatment procedures	7
Group Psychotherapy	4
Psychological Studies	11
Alcoholism and Industry	3
Legal aspects of Alcoholism	4
Follow-up Studies	6
Unclassified	9
Total	115

The answer is obvious. If you are reading this in North Carolina, *contact* your *Legislators* before they start their 1959 session. If you are reading this elsewhere, support your own State or Province program or try to see to it that you get one started if your state is not listed in Table I.

Books of Interest

HOW TO STOP DRINKING

By Herbert Brean
Henry Holt & Co., New York

183 p.p., $2.95

WE hope an alcoholic doesn't get hold of this book thinking it's the answer to his prayers, because if he reads it, he is due for disappointment. Herbert Brean wrote "How to Stop Drinking" for the moderate-to-heavy drinkers, not for the alcoholic. "This is a book about drinking, written for drinkers. Not for the confirmed alcoholic who has tried to stop drinking and found he cannot."

We fail to see the purpose of this book, other than to tell non-alcoholic drinkers how they may slow down, if they choose to. Its real value lies in chapters on what alcohol does in the body, why people drink, and the scope of the drinking problem in this country. For the drinker who finds himself in trouble and who eagerly picks up this book hoping for the answers, it has little merit and yet the very title of the book would suggest that here is the long sought-after solution to a problem that has wrecked more families and caused more heartaches than practically any other social problem in the United States. Evidently Brean chose the book's title to correspond with his previous book on smoking, not realizing how misleading he was being or how incomparable the problems of smoking and drinking are.

Brean says the public wants to determine . . . "Whether drinking is really moving us toward alcoholism or even toward problem drinking. If it is, what steps we can take to decelerate it so that we remain well this side of the trouble line and thus continue to enjoy moderate drinking all our lives. If it is nowhere near the trouble zone, how we can make sure it stays there."

This last point, Brean implies, is easy—only a matter of self-control. He also implies drink itself is the real problem, mentioning practically not at all the emotional needs of the drinker.

"There has been more study and theorizing about the alcoholic than about the moderate drinker, which is unfortunate for us, and which some people in the field are beginning to regret. It can be argued that if more attention were given the early or moderate-to-heavy drinker, there might be fewer alcoholic ones."

Brean, a layman, fills in this gap left by scientists with such chapters as "What Kind of Drinker Are You," "The Traits of the Alcoholics", If You'd Like To Slow Down", "The Techniques of Deceleration" and "The Wayside, and How Not To Fall By It."

If the reader has his mind made up to stop drinking *before* he reads this book, he will possibly find the chapter on techniques of deceleration of some help (follows basically the AA principle of 24-hours at a time). But those drinkers who are really in trouble will never admit to themselves that they have a drinking problem long enough to do more than just glance at the title and move on.—*CC*

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
615 Wills Forest Rd.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: PArk 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-Patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Display—Primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

NOV.-DEC., 1958

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultatons with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a phychologist, social worker, a recreation director, an occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Executive Director

ROBERTA LYTLE, R.N., M.S.Sc.
Psychiatric Social Work Consultant

INVENTORY

VOLUME VIII NUMBER 4
NOVEMBER-DECEMBER, 1958
RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices Old Health Bldg., Raleigh, North Carolina.

This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request. This journal will not be sent to persons other than those requesting it. Manuscripts invited with understanding that no fees can be paid.

Write: INVENTORY, P. O. Box 9494 Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

POLAND: The government of Poland is attempting to combat the problem of alcoholism in two ways. First by operating alcoholism clinics in every large city in the country and secondly by proclaiming "non-alcoholic" days, during which a ban is placed on the sale of hard liquor. Non-alcoholic days are set before the first and fifteenth day of each month, which fall on weekends and paydays.

RALEIGH: The NCARP played host at the last portion of the semi-annual conference of North Carolina Health Educators which was held December 5, in Raleigh. At the close of the regular meeting, all attending educators were invited to the ARP offices where the ARP's treatment program and educational resources were explained and discussed.

WASHINGTON, D. C.: A Research Institute on Problems of Alcohol and Alcoholism was held October 25-26 in Washington, sponsored by the North American Association of Alcoholism Programs. Funds for the Institute came from a grant of $9000 awarded to the NAAAP by the U. S. Department of Health, Education and Welfare. The Institute brought together many notable professionals working in the field of alcoholism.

CHICAGO: The "scrap iron cocktail" is the newest bootleg drink to alarm the medical profession. The concoction—popular along skid rows—is started by dumping yeast, cracked corn or corn meal and sugar into a large metal drum. Rubbing alcohol and mothballs are added. A dash of Clorox speeds up fermentation. Writing in the Journal of the American Medical Association, a team of South Carolina scientists reports that the drink produces serious mental disturbances, including tremors and hallucinations.

NORTH CAROLINA: An Institute on Alcoholism was held at Atlantic Christian College in Wilson on November 3. The Institute was sponsored by the Committee on Alcoholism of the N. C. Council of Churches, Atlantic Christian College, the Ministers' Association and the N. C. Convention of Christian Churches. Roy B. Barham, Chaplain at the NCARP Treatment Center, was chairman of the planning committee. The Institute, which was well attended by ministers of all denominations, included lectures and discussions on the nature of alcoholism, counselling the alcoholic, the minister and AA, and a case study through role playing which was directed by Roberta E. Lytle of the ARP. Dr. Norbert Kelly, ARP Executive Director, closed the Institute with a discussion of resources available for the minister.

NORTH CAROLINA: A syndicated newspaper series titled "Our Drinking Habits" has been appearing in some of the state's leading newspapers. The author is Howard Whitman, one of the nation's outstanding writers on social problems. This distinguished piece of reporting deals with today's drinking patterns and how each individual citizen may be involved. The series begins with an analysis of the Saturday night party in modern suburbia, which Whitman labels "mass anesthesia," and closes with a factual discussion of alcoholism causes and treatment.

NEW HAVEN: A native son of North Carolina—Dr. David Pittman, formerly of Rocky Mount—is co-author of "The Revolving Door", published by the Yale Center of Alcohol Studies and Free Press of Glencoe. Illinois. "Revolving Door" presents the results of a study conducted in New York State of repeatedly jailed chronic alcoholics. The book is one of a series of monographs published by the Yale Center. Dr. Pittman, professor of sociology at Washington University, St. Louis, Missouri, was a Phi Beta Kappa graduate of the University of North Carolina.

DENMARK: The world famous woman journalist, Inez Robb, recently commented on a new Danish invention—that of the perfection of an automobile engine which refuses to work the instant it "whiffs so much as a hint of alcohol on the driver's breath." The inventor, Hellweg Friborg of Denmark, declares that not even chlororphyll will help when it comes to this "electronic atmosphere-taster." Says columnist Robb, "It's just possible that Hellweg's invention would paralyze all traffic out of country clubs after 9 p.m. on any given occasion, and create such anarchy and congestion at cocktail parties that this form of entertainment, if such it be, might eventually disappear."

SAN FRANCISCO: A hostel for alcoholic men has been opened in San Francisco. The hostel will not act as a treatment center but as a rehabilitation center for men who have stopped drinking but are not yet confident enough to return to society again. Over forty patients can be accepted into the hostel at a time and admission is not subject to race, creed or color. The hostel has been named the Henry Ohlfoff House after a recently deceased Protestant Episcopal priest who long worked with alcoholics. In addition to providing alcoholics with a temporary home, the hostel plans to establish an employment service and counseling and social activities. AA groups in San Francisco are cooperating wholeheartedly and AA meetings are held regularly at the House.

BIRMINGHAM: The 1958 Southern Regional Conference on Alcoholism was held November 6-7 at the Tutwiler Hotel in Birmingham. Sponsored by the seven member states of the Conference, Alabama, Arkansas, Georgia, Louisiana, Mississippi, Tennessee and Texas, the purpose of the Conference was to promote public education on alcoholism; to activate action groups on a local level through community leaders; to serve as a liaison between state agencies and local groups and to coordinate the disciplines closely related to the alcoholic into a more effective team approach to the problem. Conference chairmen were Mrs. Marty Mann of the National Council on Alcoholism and Nimrod Frazer, administrator of the Alabama Commission on Alcoholism. The NCARP was represented by Miss Roberta Lytle, Psychiatric Social Work Consultant.

State Fair Subscriber

Please put my name on your free mailing list. I brought home a copy of "Inventory" from your booth at the State Fair. I would like to receive "Inventory" regularly.

Mrs. M. E. Taylor
Smithfield, N. C.

Thinks "Inventory" Would Help

I am a student at the Pennsylvania State University and am interested in going into alcoholic rehabilitation work after I complete my studies at a Methodist Seminary. I would like to receive copies of your magazine because I think they would help me get a better view of the problem I'll have to face in my work.

George Crighton, Jr.
Pennsylvania State College

Wants "Cornerstones"

I would like to obtain a copy of the booklet, New Cornerstones . . . My husband is a patient at the Alcoholic Rehabilitation Center at Butner. I would like to read your book so that I might better understand how to live with an alcoholic.

Anonymous
Wakulla, N. C.

College Professor Writes

While I was doing my graduate work at Duke University, I came into contact with INVENTORY and found it a most interesting and helpful publication. I should like to continue reading it. In my work as a college professor, I often meet persons who need guidance and help with the problem of alcohol.

Coburn Gum
St. Petersburg, Florida

Minister Needs Literature

I would appreciate your putting my name on your mailing list for INVENTORY and if you have any more copies of "Alcoholics Are God's Children, Too", I would appreciate your sending me a copy. Any literature which you might have which would be helpful in dealing with a referendum on alcoholic beverages which will be held in our county early next year would also be greatly appreciated.

James H. Ballard, Pastor
Cane Creek Baptist Church
Hillsboro, N. C.

A Recovered Alcoholic Writes

Since I'm a recovered alcoholic myself, I am more than vitally interested in this subject. In my Twelth Step work, I came across many people who, like myself, need more than the AA philosophy alone. I have and am still using some of your literature. Your magazine INVENTORY is the finest thing I have run across to date. Although I am a resident of New York State, I would be grateful if you would place me on your mailing list. I can promise you that it would be put to good use.

A recovered alcoholic
Rochester, New York

VOL. VIII, NO. 4 INVENTORY NOVEMBER-DECEMBER, 1958

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

THE ALABAMA COMMISSION ON ALCOHOLISM

BY JOHN L. SANDERS, M.A.
EDUCATIONAL DIRECTOR

Off to a slow start, this state forged ahead to develop a balanced attack on a major problem.

THE presence of twenty-one persons from Alabama at the 1958 Yale Summer School of Alcohol Studies heralded a new development on the alcoholism front in Alabama. Alabama's attendance record was topped only by North Carolina, a perennial contender for attendance honors.

The significance in the number of Alabamians at the Summer School lay in the fact that nineteen of the twenty-one were provided scholarships by the Alabama Commission on Alcoholism. This scholarship program is only one aspect of a greatly expanded effort in the alcoholism field in Alabama made possible by a 1957 legislative appropriation.

This appropriation of $150,000 annually was the largest in the Commission's thirteen-year history. It meant a victory that had been long anticipated and worked for by friends of the Commission. A great deal of the organized support for the 1957 bill came from the Jefferson County (Birmingham) Committee on Alcoholism.

The increased appropriation made a rehabilitation program possible for the first time, and the new legislation specifically called for the establishment of an outpatient treatment program for alcoholics. It gave the Commission's Board and administrative staff a great deal of discretion in

carrying out this objective.

After a long period of waiting, the citizens of Alabama can now realize the balanced program and forceful attack on the alcoholism problem called for in pioneer legislation passed June 16, 1945. On that eventful date, Alabama became the first state to pass a law recognizing alcoholism as an illness and at the same time establishing an agency to educate the public on the nature of the problem and to set up a rehabilitation program. This agency was given the official title of Commission on Education With Respect to Alcoholism.

Alabama's pioneering feat received relatively little national notice, however, probably because of the small initial appropriation of only $5,000. It was eclipsed about one month later by a Connecticut law which gave a larger appropriation and made possible a more extensive program. Until 1957, the Commission's appropriation never climbed above $16,000, and with a limited staff the primary emphasis was on education of the general public.

A few members of early Alcoholics Anonymous groups in Alabama, with direct assistance from Mrs. Marty Mann, were responsible for getting Governor Chauncey Sparks to sponsor the Commission's initial legislation in 1945. Individual members of Alcoholics Anonymous, in their capacity as private citizens, supplied the sustaining force for the Commission during its decade of struggle for growth and expansion.

Beginning in 1946, most of the responsiblity for the Commission's activities rested with Mrs. Inez Rach, who served as information specialist. Although faced with limited funds, she carried on an aggressive educational program which emphasized personal contact with community leaders. She attended the Yale Summer School of Alcohol Studies in 1947.

ABOUT THE AUTHOR

John L. Sanders, Educational Director for the Alabama Commission on Alcoholism, received his Master of Arts degree from the University of Alabama in political science and public administration and is currently working on a Ph.D. degree in those same fields. While at the University, he was a teaching fellow and research assistant with the Department of Political Science. Mr. Sanders is responsible for the formation of the Commission's research program.

The original policy-making structure of the Commission has remained unchanged. Hence, the people who hold the positions of State Health Officer, Head of State Hospitals, Director of the Welfare Department, Chairman of the Psychiatry Department of the University of Alabama Medical School, and Director of the Division of Vocational Education of the Department of Education are automatically members of the Commission's Board. The governor is *ex officio* chairman of the Board and is allowed to appoint two lay members, who bring the total number on the Board to seven. This seven-member board obviously lends itself to effective interagency cooperation and gives the policy-making role to professional leaders in the fields of health, mental hygiene, educational and social welfare.

Under the 1957 legislation, the present administrator, Nimrod T. Frazer, was hired in December, 1957. He was given the responsibility for planning and carrying out a greatly expanded program. Frazer immediately realized that an important first step was to take advantage of the knowledge and experience that existed in other states, especially in the area of treatment. Therefore, he visited and talked to directors of state programs in Connecticut, Florida, Georgia, and North Carolina. He also consulted the directors of the Yale Center of Alcohol Studies and visited the General Service Headquarters of Alcoholics Anonymous in New York.

Frazer concluded, on the basis of his firsthand study, that a well-balanced program should include the functions of treatment, education, and research. An effective treatment program, as he began to visualize it, would need strong support from both education and research.

The 1957 law provided a guide for the type of treatment program to establish, since it emphasized an outpatient clinical approach. Frazer found strong support for this emphasis, particularly on the part of the administrator of the Connecticut program, who pointed out that a comparison of per capita expenditure with results obtained in Connecticut revealed that the outpatient clinics were a better investment than an inpatient facility. Hence, Frazier decided, with the approval of the Commission's Board, that three clinics should be established initially and located in major population centers. Present plans call for the setting up of a network of outpatient treatment clinics throughout the state in accordance with need and staffing possibilities.

The first clinic was opened in Birmingham on July 28, and a second clinic is to be opened in Montgomery in November. The staffing pattern in the clinics is similar to that adhered to by Connecticut and Florida. Included on the staff of the Birmingham clinic are a full-time psychiatrist, two full-time psy-

Birmingham Clinic opening: L to R are Dr. E. M. Fuchs, Clinic Director, H. J. Harper, city's citizens comm. head, Nimrod Frazer and Dr. J. S. Tarwater of the Commission, and Lt. Gov.-Elect Albert Boutwell

chiatric social workers, a part-time general physician, a part-time clinical psychologist, a receptionist and a clerk-typist. The psychiatrist, Dr. Edwin M. Fuchs, is director of the clinic.

The Commission has no immediate plans for inpatient treatment. It feels that the general hospitals in the state should be encouraged to admit and properly treat acutely intoxicated alcoholics and those otherwise needing hospitalization. A survey has recently been conducted for the Commission to determine the availability of treatment for alcoholics all over the state offered by general physicians, general hospitals, state hospitals and others. This survey is considered a vital step toward obtaining a greater use of these resources in the treatment of alcoholics.

Education Supports Treatment

To make the treatment program more successful, the Commission's educational activities play a major supporting role. With rehabilitation efforts in the limelight, the education function revolves around treatment by focusing public attention on the services available to the treatment team, informs the public about treatment facilities, emphasizes the need of early case-finding and works with sources of patient referral.

The importance given to the education function was shown when a full-time educational director, John L. Sanders, was hired in February, 1958. Sanders attended the 1958 Yale Summer School of Alcohol Studies. In addition to being responsible for the education program, he is also in charge of research.

The Commission attempts to direct its educational efforts at particular professional groups as well as the general public. A professional treatment digest, originating at the Yale Center of Alcohol Studies, is mailed to 5,000 people in related professions, and select literature has been stocked with these professional people in mind. Conferences and workshops are also planned for these groups. During 1958, the Commission will have participated in the Alabama Conference of Social Work, the Probation and Parole Conference, a statewide nurses' workshop on alcoholism, and the Southern Regional Conference on Alcoholism. In addition, it plans to show a large exhibit at the State Labor Convention.

Exhibit Purchased

A fourteen-unit education exhibit was purchased from the Cleveland Health Museum of Cleveland, Ohio. It is believed to be one of the largest multiple-unit exhibits on alcoholism used by a state program. The exhibit was displayed at all of the five major fairs in the state this year, attracting considerable attention and favorable comment. It will be used in conjunction with conventions and workshops and on other occasions.

Realizing that the Commission alone cannot carry the burden of treatment and education, scholarships are provided on a competitive basis by the Commission to persons in fields where alcoholism is an immediate or related problem. Many of these recipients of Commission scholarships are expected to serve on a speakers bureau which is expected to be formally organized soon.

Other Educational Tools

Other tools used by the Commission in its education program are a film library, free literature, news releases and special radio and television programs. A bimonthly publication dealing with state news and

containing articles with general public appeal is in the planning stage.

A questionnaire survey has been made of college and public libraries to determine their holdings on alcoholism. Gift packets of books and pamphlets will soon be presented to these libraries to correct their deficiencies.

Finally, in its education program the Commission stresses the need for community responsibility and interagency cooperation. It attempts to work with local committees wherever they exist and is studying the prospects for encouraging the development of these committees. The Commission has been fortunate in establishing cooperative relations with several related state agencies. A working relationship with other departments is facilitated since the policymaking board of the Commission is composed of the heads of important state departments and divisions. This structure makes possible the channeling of information on alcoholism through sympathetic officials.

In the area of research, the Commission has concentrated on fact-finding surveys to get an objective picture of the status quo in the fields of treatment and education. In early April, an interdisciplinary committee of college professors was asked to outline a comprehensive research program for the Commission. Many of the members of the committee had previously attended the Yale Summer School of Alcohol Studies.

The first phase of this committee's recommendations was carried out this summer for the Commission under the direction of two university professors. The purpose of their study project was to determine what facilities exist in the state for the treatment of alcoholics as well as medical and hospital approaches to treatment. The results of this survey will guide the Commission in the establishment of its own treatment program.

Another survey project, which will be started in November, will be an education study to determine public knowledge of alcoholism, the Commission, and attitudes on the alcoholic problem. Once completed, this study will help give direction to the education program and provide a basis for evaluating educational efforts.

In summary, although Alabama was an early pioneer in the alcoholism legislative field, its Commission on Alcoholism, established to deal with the problem, for over a decade experienced negligible growth. A greatly increased appropriation in 1957, made possible an extensive program. This program calls for a balance between education, treatment and research. It recognizes the importance of cooperation between related disciplines and public agencies, and the Commission's staff is aware of the need for the community to accept a large share of responsibility. Finally, it calls for an objective and continuing evaluation of the total program so that better service may be provided and a more effective job done.

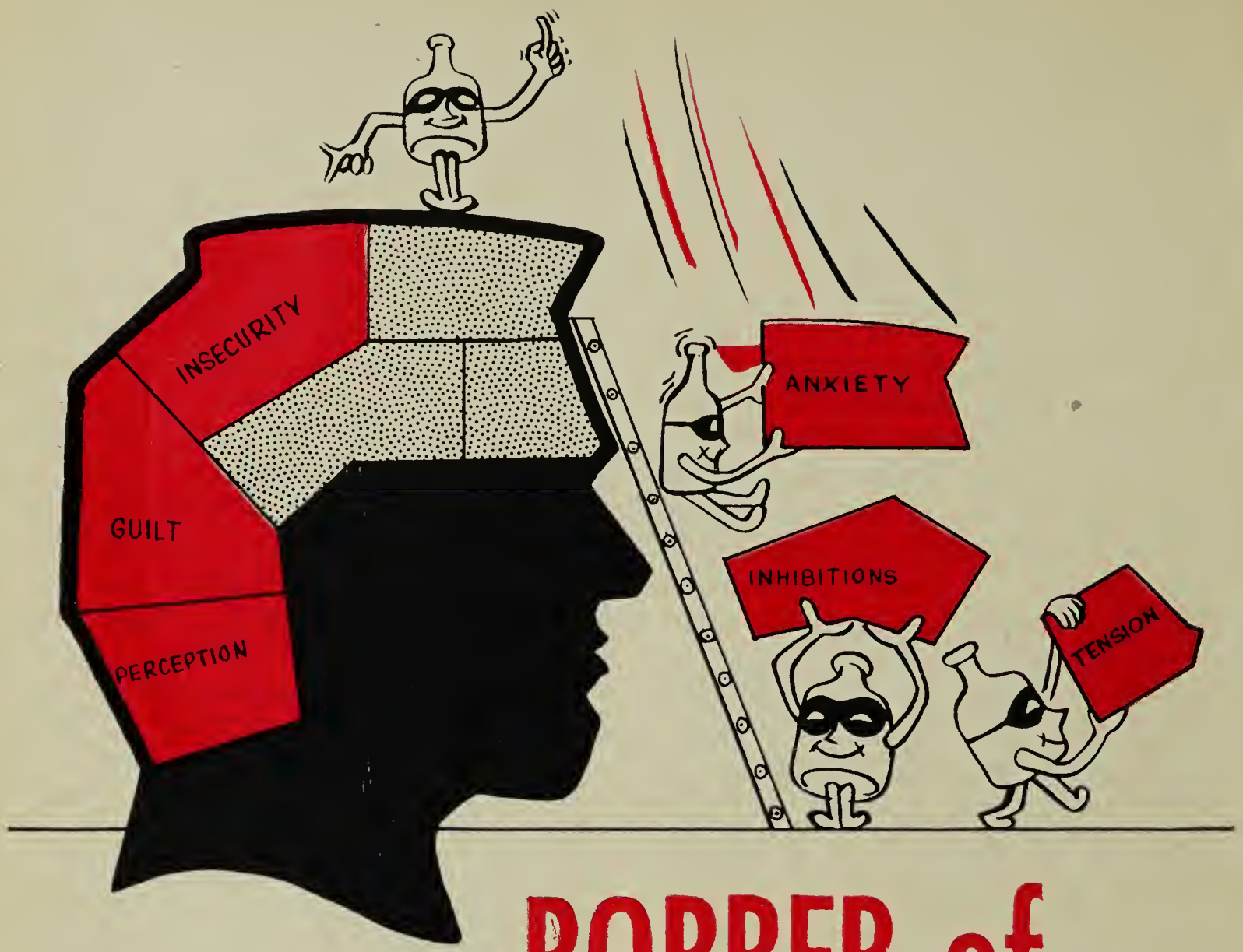
A hillbilly came to town carrying a jug of moonshine in one hand and a shotgun in the other. He stopped a man on the street saying, "Here friend, take a drink out of my jug".

The man protested that he did not want a drink.

The hillbilly leveled his shotgun at the stranger and said, "Drink!"

The stranger drank, then shuddered, shook, and coughed. "Gad, that's awful stuff."

"Ain't it?" said the hillbilly. "Now hold the gun on me an I'll take a gulp".



ROBBER of 5,000,000 BRAINS

BY MILTON GOLIN
ASSISTANT TO THE EDITOR
AMA JOURNAL

From the pages of THE JOURNAL of the American Medical Association comes this article telling of the new war on alcoholism as it is being waged by the medical profession in alliance with civic, religious, governmental, business, labor, educational, and other forces, A truly distinguished job of reporting on a highly complex subject.

THIS is alcoholism: A complex disease that prompts the unthinking to joke about drunks but can leave families homeless and penniless; a massive medical puzzler which is no less soluble because it also is a major sociological and economic problem; a public cancer that can turn some men against themselves but to which others are completely resistant; a blight so singularly human that the Bible warns against it, Shakespeare diagnoses it, and Tennessee Williams builds a prize-winning play around it.

Alcohol Not Culprit

Drink has taken 5 million men and women in the United States, taken them as masters take slaves, and new acquisitions are going on at the rate of 200,000 a year. Yet, the disease that lurks in alcohol is a fickle tyrant —choosing, unexplainably, the one drinker out of every 16 over whom it is able to exert complete control. This is because, in a larger sense, *the culprit is not alcohol.* It is alcoholism. Oddly enough, the great majority of drinkers cannot acquire this sickness no matter how hard they may try.

One who tried is a New York City physician who, purely in the interest of medical science, set out to prove with his own body that alcohol was as addictive as morphine. He loaded the trunk of his car with cases of whisky and drove to an isolated cabin in New England. There, day after day and night after night, he drank and sang and drank. But he was not happy. For at the end of one solid month in inebriation, when this doctor returned to his office to measure his cravings and physical dependency upon alcohol as a drug, only one thing was certain: He did not want to look at liquor for the rest of his life.

What the experiment did prove (and the proof is not new) was that alcoholism, like cancer, cannot be implanted in simply anyone by physiological means alone. A multiplicity of other conditions also are disease factors. Tests with animals tend to bear this out. An elephant, for example, is subject to severe stomach cramps if it is exposed to cold weather for any great length of time and will start trumpeting with pain. Its physical hurt plus accompanying psychological stress can be relieved by a large bucket of gin and ginger. But, after taking this remedy a few times the elephant becomes a crafty alcoholic, feigning pain and moaning pitifully for his daily swig. Cats have been turned into alcoholics by spiking their milk with liquor while placing them in a variety of frustrating situations. In similar tests with rats under nonstress conditions, the rodents were able to take their whisky or leave it.

An Age-Old Problem

Ever since prehistoric man first learned the technique of fermentation, he has been troubled with problems of intoxication and—as he became more "civilized"—of alcoholism. In those millenniums, drink toppled kingdoms while clergymen preached its evils; it betrayed armies while governors imposed stiffer penalties and crueler tortures on drunkards. Medical researchers more than a quarter of a century ago took alcoholism out of the category of moral dereliction. But only in relatively recent years have influential men and organizations come to realize that compulsion drinking is immune to punishment and sermonizing and that alcoholism is a disease which is best assailable under a compassionate and concerted attack by many segments of society. Like syphilis, alcoholism at last is being fought out in the open—spotlighted

as a disease that responds to treatment, rather than beclouded as an irredeemable moral failing that forever must be condemned in the individual and tolerated in the mass.

Dr. Gunnar Gundersen, President of the American Medical Association, says: "We are under no delusions that the problem can be completely solved by purely scientific methods. The physician can restore the alcoholic's physical health, calm him mentally, and help him to meet basic human problems. At the same time, however, the ultimate solution may have to come from the patient's religious counsellor, his wife, employer, or whatever source might hold the trump card for an individual case. The medical profession is cooperating with voluntary agencies, public health groups, and legal authorities in developing a unified approach to the alcoholism problem."

Who are medicine's allies in the war against alcoholism? They are clergymen and businessmen, labor leaders and schoolteachers, lawyers and bartenders, policemen and playwrights. And they are the alcoholics themselves.

Effective Fighters

Every recovered alcoholic is a particularly incisive fighter against his own disease—more thorough than the ex-turberculosis patient trying to limit the spread of tuberculosis, more effective than the heart attack survivor seeking to defeat cardiac diseases, more influential than the cancer victim hoping to ease the lives of others stricken like he is. More than 200,000 of these victims-turned-counselors next year will observe the 25th anniversary of their savior, Alcoholics Anonymous. Their "strength amid weakness" is shown today in the successful activities of 7,000 AA groups across the nation.

Yet, because the therapy of Alcoholics Anonymous tends to help only those who can adjust to the intense group life of its program, many alcoholics are not treatable through this approach. By their very nature, most alcoholics are antisocial. A New Jersey alcoholic recently put it this way to a physician: "I don't see the point AA preaches. I don't like to hear other people's troubles." Nevertheless, Alcoholics Anonymous remains one of the effective ways of dealing with the sickness. For thousands of victims it is the avenue for a life free from compulsive drinking.

Other Forces Working

Not only in AA but in the efforts of diverse organizations and individuals all across the land this disease is being fought today with a vigor never before seen. These forces are combining with the medical profession in a tone of courage, and not plodding along separately in a panicky defeatism that "something, anything, must be done."

—In New York City, clergymen and judges are joining medical leaders as lecturers in a new course established at Fordham University for social workers dealing with alcoholics.

—In Chicago, the police department operates a Fellowship Club for the rehabilitation of officers afflicted with alcoholism. Founded in 1954, it is the first organization of its kind, and is being used as a pattern by police administrators in San Francisco and other cities. A decade ago no police force would dare admit it had an alcoholism problem.

—In Westport, Conn., a volunteer citizens' committee last year began manning an alcoholism information center for that city and nine surrounding communities "to help prevent and arrest alcoholism through education in school, in the church, in the medical profession and in the

community."

—In California, a 10% liquor license fee increase which went into effect last year is helping to finance eight alcoholism rehabilitation clinics on a shared-cost basis with communities.

—In Boston, officials of the General Electric Company launched its in-plant program for problem drinkers by sending the firm's personnel workers and foremen to special evening classes on alcoholism at Boston University. Problem drinkers get team treatment and group therapy at the Boston Committee on Alcoholism clinic, which is manned by psychiatrists, psychologists, family advisors, and vocational counsellors.

—In Pittsburgh, members of the Allegheny County Medical Society's committee on alcoholism work with

WHAT IS AN ALCOHOLIC? WHAT IS ALCOHOLISM? SOME DEFINITIONS . . .

How do you define alcoholism? What is an alcoholic? A variety of answers are quoted here from observers who, in their description, not only express shadings of viewpoint but also illustrate the complexity of this disease.

"Alcoholism is a complex disease having physiological, psychological and sociological implications."

—National Council on Alcoholism

"Alcoholism is reached when certain individuals stop bragging about how much they can drink and begin to lie about the amount they are drinking."

—A. M.A. Archives of Industrial Health

"Alcoholism is a chronic behavioral disorder manifested by repeated drinking of alcoholic beverages in excess of the dietary and social uses of the community and to an extent that interferes with the drinker's health or his social or economic functioning."

—Mark Keller, managing editor, Quarterly Journal of Alcohol Studies

"Alcoholism represents the abnormal survival in adulthood of a need for the infantile normal experience of unitary pleasure of body and mind. The alcoholic rediscovers this experience in the course of intoxiation. He cannot resist its gratification, however illusory or temporary it turns out to be."

—Georgio Lolli, M. D., psychiatrist

"Most alcoholics start out as social drinkers. But who knows where the responsibility for his becoming an alcoholic lies?"

—Father Ralph S. Pfau, a recovered alcoholic, in his book, "A Priest's Own Story"

"One becomes an alcoholic when he begins to be concerned about how activities might interfere with his drinking instead of how drinking might interfere with his activities."

—World Health Organization

"A drinking man's someone who wants to forget he isn't still young and believing."

—From Tennessee Williams' "Cat On A Hot Tin Roof"

DRINKING AND DRIVING

How many drinks make a person unfit to drive? The number varies with the individual but one point appears certain: When the percentage of alcohol reaches a certain level in the blood, that person should not be behind a steering wheel. Within a few weeks THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION will begin publishing a series of articles on this subject by outstanding authorities in cooperation with the AMA Committee on Chemical Tests for Intoxication. The chairman of that committee, Dr. Herman Heise of Milwaukee, says:

"Many people firmly believe that if they don't run into a hydrant as soon as they drive with a few drinks under their belt, and have actually negotiated long trips in spite of a load of alcohol, then alcohol does not affect their driving. The loophole in such reasoning is that no man can judge the effects of alcohol on himself when all his judgments are somewhat addled by alcohol."

Dr. Heise believes that if all drinkers—not merely alcoholics—could be divorced from driving, "possibly half of our 40,000 people doomed to die on the highways could live, and a half million more could be spared from painful and crippling injuries." His viewpoint is shared by New York Traffic Commissioner T. T. Wiley, who only a few weeks ago challenged the nation's leading electronics engineers to develop a device that would automatically stop a car if the driver were drunk.

It is in New York that records recently pointed to the possibility that we may be greatly underestimating the impact of driver intoxication upon motor vehicle deaths. These records showed that a full 55% of all motorists killed in New York City last year had been under the influence of alcohol. A similarly high proportion of traffic fatalities among drunken drivers is reported in surveys being studied by the AMA Committee on Medical Aspects of Automobile Crash Injuries and Deaths.

police, judges, prosecutors, and the local bar association to help provide expert testimony when motorists are accused of driving while intoxicated. The physicians do this by operating a breath analyzing machine in the police station and appearing in court on specific cases.

—In Minneapolis, when a Foundation on Problem Drinking was set up recently, among those volunteering their services (along with physicians and social workers) were bartenders and policemen. The bartenders are proving valuable in recognizing alcoholics and counselling them, and police have learned to detect early signs of alcoholism so that these drinkers can be taken to the Foundation instead of the jail.

—In Buffalo, for the first time in the history of labor-management relations, an arbitrator recently ruled on a case involving an employee fired for being an alcoholic. The decision favored the employee, a television announcer, on the basis of medical testimony—and scolded the broadcasting company for ordering the discharge "without seeking medical advice on his condition and prognosis."

—In Birmingham, Ala., seven companies and 17 unions have joined their efforts to help alcoholic workers.

—In New York, in a few weeks, a special conference is scheduled to frame proposals for specific alcoholism programs and services as part of official AFL-CIO policy. Already thousands of union counsellors across the United States have been trained to recognize alcoholic workers and refer them to proper medical service and allied agencies.

Alcoholism case-finding is an even more important goal of management, as it seeks to help the problem drinker before he reaches the full compulsive stage of his illness. It is not the

raucous drunk swaggering on the job who poses the big problem for business and industry. These fellows are exceptions. The typical alcoholic employee or executive appears deceptively normal. But he sneaks his drinks. He douses his hair with cheap perfume and may talk through the side of his mouth in an attempt to camouflage his breath. He is a "half-man" on the job—displaying enough responsibility to prevent him from staying home, but performing 50% or more below normal.

The medical director of one West Coast aircraft firm makes a practice of calling at the homes of workers who, possibly as problem drinkers, consistently fail to show up at the plant on Mondays. On one such visit he discovered to his amazement that a plant supervisor who happened to be his personal friend was an alcoholic. "I was completely fooled," said the doctor. "Never suspected he was a compulsive drinker. He was pitifully drunk. Lucky I found out because now I can help."

Company Treatment Centers

Some companies operate their own alcoholic rehabilitation programs, complete with specialized medical facilities. Other firms band together to underwrite treatment centers. These facilities, often functioning also as a service for the entire community, include the highly effective Chicago Committee on Alcoholism (supported for the community by 300 companies), the Clinic for Alcoholism at New York University—Bellevue Medical Center, and the clinics of several dozen local committees and agencies affiliated with the National Council on Alcoholism. The NCA is an independent group that fights alcoholism as other voluntary health agencies combat cancer and heart disease.

What stands out in every community battle against alcoholism is the judgment of the physician. It is he who decides when, if, and how tranquilizers, vitamins, and the abstinence-training drugs shall be used. He is medicine at work in an even larger role, however—guiding and observing, researching and coordinating, evaluating and mobilizing, sympathizing and debunking, inspiring and persuading. He is defending patients from abuse, pioneering new concepts, trying to do a job of preventive medicine. The rub is that not enough physicians are doing this. There are still many doctors who shun the problem drinker as a patient.

At the same time, however, thousands more—particularly general practitioners—are now beginning to realize that the burden of treating an alcoholic no longer need be borne by them alone—that there are growing numbers of medical and non-medical resources available to help in the task. And where community resources are not available, some physicians are taking the initative in organizing these facilities.

Alcoholism is, perhaps, the only major public health problem which taxes the private physician's total knowledge, wisdom, patience, skill, and compassion to the utmost—for the chronic inebriate stands alone in his challenge as a patient. Yet, by working with outside resources in helping to bring about recovery, the doctor is saving not merely a patient but a family and families to be; salvaging an integral element of the community; benefiting the lives of many people he may never know or even see. Dr. Marvin A. Block of Buffalo, Chairman of the A. M. A. Committee on Alcoholism, describes medicine's role this way:

"In the chronic alcoholic we are dealing not only with a sick indivi-

(Continued on page 18)

A SERENE and H

1959

"God, grant me the serenity to accept things I cannot change, courage to change things I can, and wisdom to know the difference."

APPY NEW YEAR

The Staff at ARP

(Continued from page 15)
dual but with that individual in relationship to his environment. There is no miracle drug that will do away with the illness. There is no known cause of this disease, no foolproof method of picking out victims in advance. An alcoholic's proneness to the disease is a secret between him and the bottle. And so the physician must not only rehabilitate his patient physically, he must help him to mature emotionally. This requires time, investigation, and patience—one does not scold a sick person. We cannot afford only to be doctors. We are also citizens. This means that it is also the responsibility of physicians to do such things as help mobilize lay forces fighting alcoholism, and inform legislatures of what they think should be done to help solve the problem. For it is a problem which ultimately affects—sociologically, psychologically, and economically—every single man, woman, and child in the United States. The physician has in the alcoholic a challenge from which he cannot retreat."

One reason that alcoholism is such a difficult disease is that its exciting agent, alcohol, is a two-faced creature—a liquid that holds both good and evil, that can provide release or can enslave. Without doubt, this mysterious and sometimes unpredictable catalyst of the brain has some therapeutic value as well as harmful effects. While alcohol is not a specific or cure for any disease, in moderate doses it can offer the noncompulsive drinker needed relaxation from the cares of the day, help relieve the pain of rheumatoid arthritis, stimulate the appetite, aid digestion, and prove helpful in relieving some symptoms of the common cold (by providing warmth and comfort, inducing drowsiness, and creating the desire for rest). While alcohol is a depres-

FACTS ON ALCOHOL AND ALCOHOLISM . . .

As little as 0.04% of alcohol in the blood may reduce visual acuity as much as the wearing of dark glasses after sundown.

At least half of all general hospitals in the nation, more than 3,000, now handle alcoholics routinely as patients, as a result of recent recommendations of the AMA House of Delegates and of the American Hospital Association's board of trustees. In contrast, four years ago an estimated three out of every four hospitals were refusing to admit patients suffering from alcoholism; little more than a decade ago less than 100 hospitals were accepting alcoholics.

Alcohol is chemically related to ether, chloroform, and other anesthetic drugs.

Alcoholics are extraordinarily rare among Jews. The reason is not known for certain, but one recurrent theory is that a dignified respect for wines at closely knit family rituals during childhood may be a factor.

For reasons not yet fully determined, more alcoholics per capita are reported in San Francisco than in any other city of the nation. The incidence there is nearly four times that of the over-all U.S. rate.

sant, in small amounts it might improve awareness, too.

At the Yale Center of Alcohol Studies not long ago, for example, a battery of beer-guzzling volunteers proved that they could outperform their non-drinking counterparts in a series of special machine efficiency tests. At present, 1,000 beer-drinking volunteers are undergoing additional experiments of this sort at Yale.

And in a similarly surprising case, a casual imbiber recently caught a television crew and audience off guard in a large city. According to script, the man was supposed to illustrate the dangers of alcohol by first operating a driver testing machine in a sober condition and then with drinks under his belt. But it didn't work out that way. At the start, the subject was nervous in a strange situation and he scored badly. The drinks then calmed him down so effectively that his second driving test was perfect. Television cameras recorded the experiment faithfully, much to the puzzlement and frustration of the show's uninformed producer, who felt right then it was he who needed a drink. Had the drinking man in the studio been driving a real automobile instead of operating a stationary testing device, however, his "score" might have been tragic. The chief danger in driving after a few drinks is the soaring confidence which leads to taking of chances.

Of course, here we are referring to alcohol used in moderation, and not compulsively. There is a distinct difference between most imbibers and those who cannot stop drinking.

The "good" face of alcohol sometimes may be difficult to recognize, particularly by those well-meaning persons who advocate prohibition as the only solution to "the evils of drink." The repeal of Prohibition 25

AND MORE OF THE SAME . . .

By gradually consuming half a highball or three quarters of a can of beer every 60 minutes, the "average" adult can drink 24 hours without becoming intoxicated. (This is the average rate of alcohol oxidation by the human liver—and, of course, no individual is average.)

Alcohol cannot be detected on a person's breath. What is smelled is the flavoring of the drink.

Nine out of 10 alcoholics in the U. S. are not Skid Row drunks, but rather men and women in every walk of life, at every level of society, and in all ranges of income.

Approximately one-fifth to one-third of all alcoholics in the U. S. are women.

It usually takes 7 to 17 years of drinking for a potential alcoholic to acquire the disease full-blown. Many drinkers cannot become alcoholics no matter how hard they may try. One out of 16 adult drinkers in the United States probably is or will become an alcoholic. There are an estimated 80 million drinkers in the nation.

Many alcoholics actually dislike the taste of liquor, and drink it solely by compulsion and for its effect.

years ago ended an era in which alcoholics and controlled drinkers alike experienced rotgut suffering amid an inevitable lawlessness that extended far beyond the speakeasy.

"It is unreasonable to stop the manufacture of alcoholic beverages simply because a comparatively few are harmed by them," says Chairman Block of the A.M.A. alcoholism panel. "It can be compared to prohibiting the sale of sugar because our diabetic population would be harmed by the excessive use. The problem of alcoholism is in the one who uses it, not in the beverage."

Medical And Moral Concept

Perhaps this is as much a moral principle as it is a concept of medicine. In fact, with the possible exception of mental illness, no single bodily disease is receiving so much concurrent attention from medicine and religion as is alcoholism. The extraordinarily close rapport of clergymen and physicians in the United States has brought about a beneficial interchange of attitude and action toward the alcoholic. Doctors now refer many of these patients to religious counsellors and also have deepened their own compassion during treatment. More and more ministers, meanwhile, are realizing that the moral implications of alcoholism are primarily effects rather than causes of the disease. As a result, what once had been a predominant church attitude of condemnation of alcoholics as sinners is now being overshadowed by a larger view—a view that faith in the promise of a better life through complete abstinence is an integral part of total medical care. Listen to how a few church spokesmen portray this change in clerical thinking:

FATHER RALPH S. PFAU, the Catholic priest who, as a recovered alcoholic, exposing his own past problems and suffering, has helped thousands of addictive drinkers to lives of sobriety—"After 14 years of intermittent drinking, which sometimes found me taking a fifth of whisky a day, I learned that I am neither immoral nor weak-willed. I am sick, as sick as I would be if I had diabetes."

REVERENED FRANCIS W. McPEEK of Chicago—"It is understanding which intelligent churchmanship must seek, not a scapegoat. It is well for us to begin with an honest confession of complicity in the sin of the kind of world which can produce alcoholics."

JAMES RENZ OF THE CHURCH OF THE BRETHREN—"The church of 1958 is on the move. There are more ministers who understand the problems of alcoholics, are trained counsellors, and have the scientific knowledge and experience to lead out in programs of alcoholism rehabilitation."

REVEREND JOHN SUTHERLAND BONNELL OF THE FIFTH AVENUE PRESBYTERIAN CHURCH in New York City—"The alcoholic is a sick person. The disease is much harder to cure than pneumonia. Alcoholism shows that man may be the greatest enemy of his own body."

Killing The Enemy

How, then, does a physician decide on the best source of religious therapy for his alcoholic patient—to kill the enemy within while saving the body? Dr. Donald W. Hewitt, chief medical advisor for the Charity Alcoholic Rehabilitation Center in Los Angeles, replies: "The physician can refer the alcoholic to someone who will reassure his patient that God is a loving, forgiving Father who is willing to blot out and forgive any sins if the alcoholic is only contrite and repentant. An alcoholic already is suffering truly excruciating physical

and mental anguish. Portraying God as a stern, unrelenting Deity who inexorably demands His pound of flesh for each sin committed will often load down the alcoholic with what he feels is an insupportable burden that only further drinking can ease for him."

Emotional burden is inevitable as a factor in alcoholism. In fact, some researchers believe that, but for the repressions, strains, and guilt which appear to be part and parcel of our complex society, there might be no alcoholism problem at all. They point out that the disease is practically unknown in the less inhibited primitive cultures, where there may be alcoholic sprees and even extreme intoxication, but no compulsive drinking, which is the distinguishing mark of alcoholism.

The tensions and anxieties of our modern societies also are related to an increase of drinking among women in the last several decades, according to Psychologist Edith S. Lisansky, an authority on women alcoholics. But she adds that there is little evidence of any dramatic rise in the incidence of alcoholism among women. Estimates of the number of women alcoholics in the United States range from one million to two million. Only in recent years, with wider public appreciation of their problem as a disease, have many women come out of their solitary drinking to seek relief.

Dr. Lisansky believes that a mother addicted to drink produces an even greater disruption of family life than does the alcoholic father. In either case the behavior of an alcoholic parent can be so unpredictable and unintelligible to a child as to generate irrational guilt and stress in the youngster. One researcher at the Yale Center of Alcohol Studies expressed it this way: "When father is leading up to a drinking episode the children are put on their best behavior. When the drinking episode occurs, it is not surprising that the children feel that they have somehow done something to precipitate it."

Family Receives Treatment

Thus does such emotional interplay suggest a basis for communicability of the illness. If this is true, why not attack alcoholism through the entire family unit rather than treat only the stricken one? Evidence now shows that this is exactly what is being done on an ever-widening scale. There are several instances where therapy for the sober spouse solved the alcoholic's problem. Research is going on now to learn more about the part husbands and wives of alcoholics play in perpetuating the drinking. Recently at Johns Hopkins Hospital, alcoholics and their wives were treated in concurrent group therapy sessions which emphasized the marriage. The aim—so far marked with gratifying success—has been to build a hopeful attitude for recovery by working things out as a family unit.

This approach is but one speck on the horizon as the new push against alcoholism gathers steam. These are other promising developments for

the future:

—From a preventive standpoint, portrayal of alcoholism in public school programs is becoming increasingly realistic. The early manner of characterizing alcohol as a nightmarish devil is being replaced by a factual approach describing its limitations and effects.

—Variations of group therapy are being tried out in different parts of the nation in an effort to broaden the beneficial work of organizations like Alcoholics Anonymous. Encouraging results are reported, for example, at the Eastern Oregon State Hospital, where alcoholism patients meet regularly to take turns putting one of their number on the spot with merciless questions and arguments regarding their compulsive drinking.

Preventive Research

—New concepts as to the cause of alcoholism are being explored and collated with research findings in an effort to find a way to prevent the disease—or, at least, to spot it in potential victims at an early age when preventive measures might be attempted. One medical researcher in the subject, Dr. Giorgio Lolli of New York City, has been examining the thesis that "alcoholism is a disorder of the love disposition" originating in childhood frustrations. Other new concepts being examined and re-examined concern nutritional, body chemcial, and hormonal characteristics of the disease and its victims.

—The Center of Alcohol Studies at Yale University in a few years expects to announce results of a research project now under way to determine why some patients in the various state alcoholism clinics respond to treatment while others do not. Similar research has begun in New York as part of a $250,000 program to attack the problem of chronic alcoholism along educational, social, clinical, psychiatric, pharmacological, and other lines.

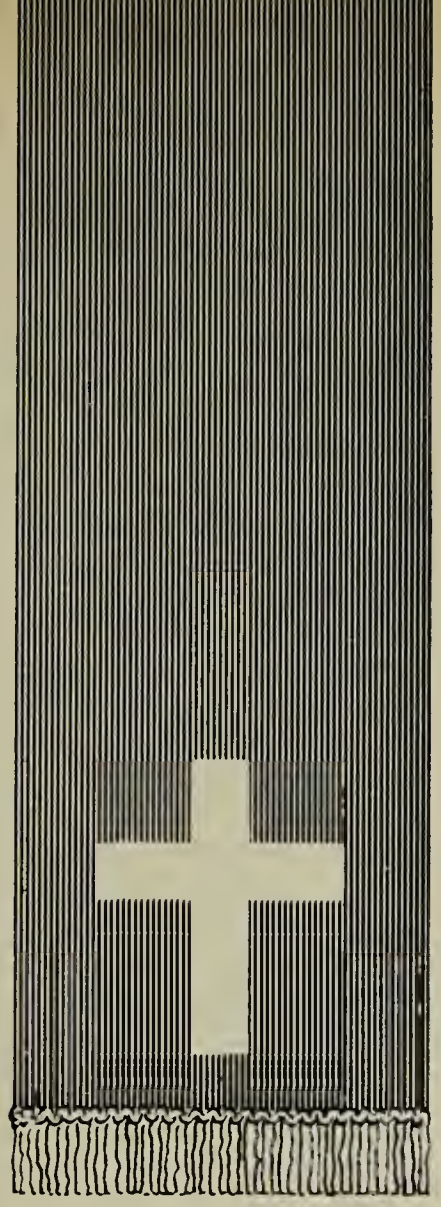
—The A. M. A. Law Department, in cooperation with the Committee on Alcoholism, is considering plans to produce a survey manual which would contain summaries and analyses of state and territorial laws on alcoholism. This could inform the physician in any state of his obligations, responsibilities, and powers regarding care, treatment, and commitment of alcoholics.

—With the encouragement of members of Congress, the National Institute of Mental Health this month was laying plans for supervising a $700,000 research program to study the physiological, psychological, and environmental factors behind alcoholism. It is the first large-scale federal effort against this disease.

—There is evidence already that, while more effective alcoholism case-finding is bringing this illness out into the open, consumption of alcoholic beverages on a per capita basis is dropping sharply. A recent Gallup poll showed that since 1945 there has been a decline of 18% in the ratio of alcoholic beverage consumers to total adult population. This indicates that in the past 12 years the beer and liquor industries "lost" 13 million customers.

Hopes For The Future

These are the promises of the future—less drinking, more effective approaches to those who drink excessively, prevention, and better understanding through research. The promises have a firm foundation in a war that has physicians fighting alongside citizens in virtually every field of endeavor. "The A. M. A.'s program is one of total assault," says Dr. Gunnar Gundersen, President of the Association. "Medicine is on the firing line against alcoholism and is hauling up more ammunition."



LET'S PROMOTE EMOTIONAL HEALING IN OUR CHURCHES

BY CLAIRE CHENEY

Years ago the Emmanuel Movement showed us that religion and psychotherapy can work together. It can be done aagin.

QUITE often the ARP receives letters from ministers of all denominations asking for information and literature which will help them in their counseling of alcoholics. Although each denomination has taken a stand on the morality of drinking alcoholic beverages, the minister often finds himself unable to cope with the various emotional and psychological disturbances the alcoholic exhibits; the hostility he feels towards his family, his church and society in general, the myriad fears and anxieties he faces and tries to drown in alcohol, his dependency and resentments, and most of all his guilt feelings for having "sinned."

We can and do give the inquiring minister advice on counseling procedures and what we have to tell him is perhaps helpful, but a minister has many duties to perform in a parish. He must be a psychiatrist, counselor, business man, public relations expert, fund raiser, theologian and preacher. Counseling alcoholics and families alone could take up all of his time and he must consider others in his parish who have problems aside from alcoholism. Therefore it seems up to the church as a whole to become concerned with this problem of alcoholism and the emotional health of everyone in the church.

American organized religion has in the past taken a stern and absolute approach to excessive and compulsive drinking which is very much akin to Puritanism. Churches have been greatly concerned with the fact that people drink to excess and the

immorality of it rather than the reasons why these people find alcohol so attractive as to give up everything in order to have it. There are reasons why alcoholics deviate from society's norms and to preach sin and guilt and punishment is to do nothing more than antagonize the alcoholic to the point where once he is willing to seek help, he will not come to the church. For why should he, if he is to find rejection, disgust, and moralizing? At this point in his life, the alcoholic needs love, real love, not puritanical explanations of how the devil has taken hold of his soul. Jesus knew this and was nonauthoritarian in his dealings with people, understanding of those who had sinned. He condemned no one, reserving His anger for the self-righteous and the moralists.

Attitudes Are Changing

Many churches are now realizing their past mistakes and are gradually but surely changing their concepts regarding this illness, but there are far too few churches who are really doing anything about it, and as any therapist knows, the alcoholic needs rehabilitation in his physical, psychological and spiritual life. And the only direct source of spiritual rehabilitation for the alcoholic is through the church.

We have heard some ministers say when asked what they would do for an alcoholic if he should come to his study for help, "I would pray with him and we would ask the Lord's help." Prayer, though as beneficial and cleansing as it is, is not the only answer and the minister must be careful of the type of alcoholic he asks to pray with him. To many alcoholics, prayer is synonomous with guilt and he already feels guilty enough w i t h o u t having "some preacher rub it in." Many feel that prayer is the minister's way of "Lording it over him", making him feel an outsider because he, the minister, knows the alcoholic rarely prays. The alcoholic wants help *right then* from the minister himself, as one human being can help another. Reverence and appreciation of the Lord's healing power can come later, after he feels completely accepted by the minister and the church.

If the church is healthy, warm and loving in its atmosphere, accepting and understanding of those who have strayed (which would include the entire congregation for none of us is guiltless), then many an alcoholic would not be forced to go to the tavern to find fellowship. In his poem, "The Little Vagabond", William Blake describes the alcoholic's feeling about the church with "Dear mother, dear mother, the church is cold, But the ale-house is healthy and pleasant and warm."[1]

Basic Christian Principles

In working with the sick alcoholic, the church can change its atmosphere from this cold, rigid place Blake speaks of to one healthy, pleasant and warm through a re-evaluation of its concepts of mental health and an examination of the basic principles and traditions of the Christian Church. A church that is cognizant of the emotional and psychological reasons behind human behavior will recognize that scolding and rejection will only perpetuate more deviant behavior, whereas love and understanding, which does not mean pampering or babying, will act as an agent for building healthy personalities.

But the church must go further than just offering passive love. It has an opportunity to offer a great service to the alcoholic as a therapeutic agent, for what therapist has a more

natural entree in the personal, intimate lives of alcoholics and their families than the minister himself? An example of what one church can do in the area of emotional healing and rehabilitation was set forth in the Emmanuel Movement, a "preventive psychiatry" church movement which began in 1906, at the Emmanuel Episcopal Church in Boston. Although we are not advocating that this movement be re-activated per se, there is much to be learned from this first church-sponsored experiment in psychoreligious therapy which could be used by ministers and church groups today.

The Emmanuel Movement

The Emmanuel Movement was founded by an Episcopal clergyman named Elwood Worcester and his associate, the Rev. Samuel McComb. For many years Worcester was convinced that the church had a responsibility to the emotionally sick and that the clergyman and physician should work more closely together. The Emmanuel program of therapy was adopted and consisted of three basic elements; group therapy administered through classes; individual therapy administered by the minister and clinic staff; and personal visits and special attention paid the ill person by "friendly visitors", members of the church who were accepting and understanding of the emotionally ill.

By 1909, the Emmanuel Movement had spread to Great Britain where it organized under the name, "Church and Medical Union." The clinic at Boston was swamped by patients. Hundreds of clergymen and many physicians came to Boston to study the methods. During one six-month period, over 5,000 applications for treatment came to the clinic, but only 125 patients could be accepted. Worcester stayed on as rector at Emmanuel until 1929, when he was forced to resign in order to give full time to his therapeutic work. The Emmanuel Movement came to a close with Worcester's death in 1940.

The only requirements that an alcoholic had to have in order to be accepted into the clinic was that he be at "the bottom" and that he accept full responsibility in asking for help. Classes were held once a week, with alcoholics and all others suffering from emotional illnesses all lumped together. The classes included discussions of anger, insomnia, nervousness, resentfulness and the power of prayer. One clergyman of that period wrote in describing the classes:

"Any Wednesday evening from October until May you will find, if you drop in at the Emmanuel Church, one of the most beautiful church interiors in the land filled with worshipers . . . A restful prelude on the organ allures the soul to worship. Without the aid of any choir several familiar hymns are sung by everyone who can sing and many who cannot. A Bible lesson is read. The Apostles' Creed is said in unison. Requests for prayers in special cases are gathered up into one prayerful effort made without the help of any book. One Wednesday evening Dr. Worcester gives the address, another Dr. McComb, still another some expert in neurology or psychology. The theme is usually one of practical significance, like hurry, worry, fear, or grief, and the healing Christ is made real in consequence to many an unhappy heart."[2]

Prospective Patients Examined

The clinic was the heart of the Movement and before a patient was accepted for treatment, he had a careful diagnostic examination by a physician or psychiatrist. No psychotic patient was accepted. During the early period of treatment, alcoholics were seen every day until old habits were broken through the constant support of the therapist. Later they

were graduated to once a week. The aim of therapy was to reorganize the patient's inner life, until he no longer needed alcohol as a crutch. Usually treatment lasted several months.

The first phase of therapy had as its object full self-revelation; the patient poured out everything that might have bearing on his illness, with emphasis on his early childhood years. This "pouring out" served as a catharsis. This second phase consisted of prayer and counsel, with emphasis on the techniques of prayer and the strengthening of the patient's spiritual life.

"Therapeutic Suggestion"

In the third phase, the patient was told to relax and Worcester used the technique of "therapeutic suggestion" which was performed while the patient was under mild or deep hypnosis. For alcoholics, however, Worcester did not favor hypnosis, for he thought alcoholics needed more than "suggestion" to cure their ills. As Worcester's methods became more developed and as he came under the influence of Freud, less and less emphasis was placed on this third phase of therapy.

Based upon Worcester's feeling that more than anything else the alcoholic needed a personal, sympathetic friend who would encourage him and offer him support during his first days of sobriety, the Movement's "friendly visitor" plan was set in motion. A committee was formed, consisting of a few social workers and informed lay persons who paid periodic visits to the alcoholic and his family. As alcoholics in treatment gained self-reliance, it was found they themselves made effective "visitors" to alcoholics just beginning treatment, an idea AA later developed full-scale.

Perhaps the Movement's most important concept was its belief that man was not depraved or lost in sin. Man's spirit is a part of God, Worcester felt, and there is hidden wholesomeness in all men. This positive concept had as its goal man's freedom from his neuroses. When man is set free, the energy which was formerly used for bad, can then be channeled into healthy, divine uses. Worcester found prayer an important means of releasing man's useful energies.

The Emmanuel Movement came into being twenty-seven years before Alcoholics Anonymous. It was the first movement that recognized alcoholism as an illness and for that reason alone was considered revolutionary. The Movement's concept of alcoholism and great understanding of the psychodynamics of human behavior was in sharp contrast to the moralism connected with emotional illness at that period in history. Rather than being concerned with the alcoholic's specific "sin", the Emmanuel approach sought to discover the underlying reasons behind anti-social behavior. In other words they were concerned with the sick personality and the symptoms of the sickness.

Guilt Lessened

This approach was greatly instrumental in relieving the alcoholic's terrific guilt load. Prayer was not directed at the offender's sin, but at spiritual rejuvenation through forgiveness. When the alcoholic felt that his behavior was beyond the realm of will-power, his guilt was lessened and replaced by the positive idea of self-acceptance. And when Worcester himself accepted the alcoholic so heartedly as a worthy human being, wholesome in the eyes of God, the alcoholic came to forgive and accept himself. Religious change rarely

came through dramatic conversion, for Worcester saw the limitations of the evangelistic approach when working with alcoholics, but through gradual, sustaining change that was made possible through teachings and group discussions. As the alcoholic became aware of an "inner spiritual self" that had formerly been locked up within him, a self that could elevate him above his hatreds, resentments and anger, his sense of achievement at this improved condition, coupled with sustained group and individual therapy, enabled him to find sobriety.

A reorganization of the Emmanuel Movement in our churches would be impractical today, nor is a movement of such a wide scale really necessary with help available from treatment centers, out-patient clinics, and Alcoholics Anonymous. But churches today are not carrying their part of the load, even though their ministers are becoming more and more aware of alcoholism as a social as well as spiritual problem, and there is increasing awareness of the need for education about alcoholism and the alcoholic.

Educate The People

First, basic attitudes must be changed and not on just the part of the church leaders alone. At a recent Institute on Alcoholism for Ministers, we heard a minister say that if an alcoholic came into church on a Sunday, the congregation would throw him out. The problem here is not one of educating the minister, but educating his people. The responsibility for changing these attitudes lies on the shoulders of the minister, through organization of church classes on mental health and alcoholism and by setting an example for the congregation to follow. Welcome alcoholics into the church. Urge them to attend services, visit their homes, but be sure to gain their confidence before bringing up the subject of drinking. Encourage their families to seek help from Al-Anon. Let them know that you understand them and want to help them, and what's more that you *know how* to help them. Find some "friendly visitors" in your own congregation who will offer support and encouragement to the alcoholic. Pray with the alcoholic, but do it wisely and with judgment and be sure the alcoholic is ready for it and understands what it means.

A Few Principles

These are just a few principles the Emmanuel Movement has taught us. There is much to learn from it. Its story should cause organized religion to stop and think of today's inadequate treatment facilities, faulty conception of emotional illness, and the prevalence of neuroses of all kinds. Preaching sin and punishment only fosters these conditions; indifference on the part of the church is perhaps even a greater sin than those the alcoholic is said to have committed. The Emmanuel Movement has shown us how religion and psychotherapy can come together to form an effective program of rehabilitation for the alcoholic. To those who would question the ethics of this, it must be said that any social problem is an ethical problem, and finally, a religious problem.

The alcoholic is looking for God in a bottle. He must be shown that God is all around him.

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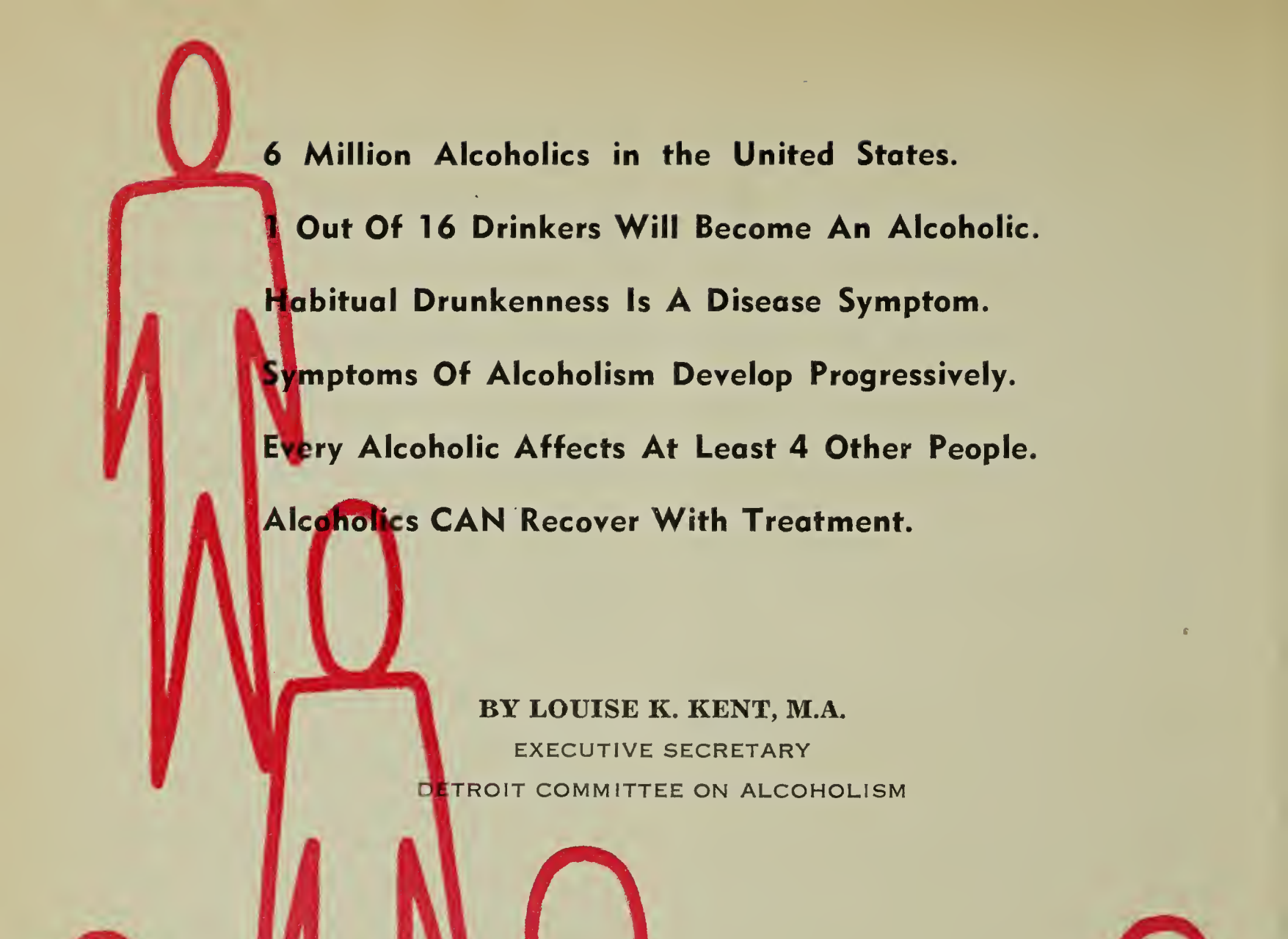
1. Understanding and Counseling the Alcoholic by Howard J. Clinebell, Abingdon Press, New York, 1956, pp 233.
2. *Ibid,* p. 96.



6 Million Alcoholics in the United States.

1 Out Of 16 Drinkers Will Become An Alcoholic.

Habitual Drunkenness Is A Disease Symptom.

Symptoms Of Alcoholism Develop Progressively.

Every Alcoholic Affects At Least 4 Other People.

Alcoholics CAN Recover With Treatment.

BY LOUISE K. KENT, M.A.

EXECUTIVE SECRETARY

DETROIT COMMITTEE ON ALCOHOLISM

WHAT SHOULD WE TELL PEOPLE ABOUT ALCOHOLISM?

WHEN we examine the fact that until relatively recent years little progress was made in changing attitudes toward the alcoholic, we must conclude that strong and significant values are held that *inhibit* a real recognition of scientific facts presented about the nature of alcoholism and the alcoholic.

In general, Americans are very ambivalent on the subject of alcohol. There has always been the stigma attached to the "confirmed drunkard" as he used to be called and still is occasionally. Particularly since World War I there has been an acceptance of excessive social drinking and/or drunkeness among some subgroups in our culture. Cocktail parties, "the man of distinction" and so on have engendered the idea that drinking is not only pleasurable but also sophisticated, socially correct and an integral part of "gracious living". Drunkenness is culturally sanctioned in some groups. Scientific statements such as "1 out of 16 drinkers will and do become alcoholics" may be momentarily the cause of disquiet and concern, but many people do not *want* to recognize that alcoholics are not a race apart but members of our community. Neither do they want to recognize cases of alcoholism in friends or family members, in employees or neighbors. Why? Because we go back to the old attitudes, to the idea that it is a moral dereliction rather than a treatable disease. Just so long as we have social controls that tend to make the victim, his family, friends or employer seek to hide the problem or ignore it until the illness is far advanced, case-finding and treatment will be an uphill struggle. Part of the difficulty, we must recognize, is that *the alcoholic himself* holds these same values. This makes him ashamed to present himself for treatment, and ashamed to have it known he is in need of treatment. It makes him defensive when help is offered.

If we consider the larger community of which we are a part, we must be keenly aware of what Dawson called "the peculiar duality of our civilization". We are the intellectual products of two great traditions: Christianity and science. Besides this duality, we have in the United States —in our community as a nation—a still further confusion in ideals of Christian love, brotherhood, private enterprise and democracy. Add to this the ambiguity of roles resulting from the changing roles of men and women, of children and parents, and from the changing functions of the family itself in relation to the community. In a culture already profoundly affected by and not yet adjusted to the rapid urbanization and industrialization this country experienced, we have all these factors as well as the more universal anxiety about war, the hydrogen bomb, total extinction and so on. We all live under conditions that conduce to great stress and keep our equilibrium with varying degrees of success.

Psychologically Vulnerable

I have mentioned these influences on the American people to make the point that our cultural configuration is conducive to the formation of conditions that cause traumatization and emotional deprivation of personality. Dr. E. M. Jellinek, who has long been a most careful student and researcher in the field of alcoholism, with the World Health Organization, believes that Americans are particularly "vulnerable" to addiction to alcohol, that is to say, psychologically vulnerable.

One of the most encouraging aspects of the present picture is the amount of educational-preventive work that is being done and the in-

terest in it which is evidenced by requests from groups for information, for the presentation of scientific facts on the subject of alcoholism. If the knowledge gained is usable and communicable, the individually-acquired gains shall have a profound significance for the future. As Dr. Clinebell says, if it were generally accepted that the frequent use of alcohol as a means to interpersonal adjustment can, and too frequently does lead to alcoholism; if it were generally recognized that habitual drunkenness is the symptom of a disease; if the consequences to both the personality and the community and the nature of the social problems created by alcoholism were understood, then hopefully a new climate of public opinion would come into being. Cultural attitudes toward drunkenness would exert pressures against it, rather than encouraging or accepting it. All of us know the social controls exerted by the mores of our culture are far more effective in exerting control than codified law—witness the Volstead Act, and the farce of the prohibition era, with impossible law enforcement. Sometimes in attempting to alleviate a social problem, greater problems are created. Too, we must always remember that there are areas of privacy in the lives of the citizenry where legislation is completely ineffective.

Objectively presented facts about alcoholism are as well-accepted and considered by college students as facts about divorce, suicide, juvenile delinquency, industrial problems or any other social problem. The deep roots of any cultural sanction are not created by any short-term procedure and neither can we expect immediate results from social education. However, given the excitement of ideas and the principle of social change the ultimate success and effectiveness of properly directed preventive efforts cannot be doubted. In the proper setting, simple statements such as "1 out of 16 drinkers will become an alcoholic, according to estimates from studies made", and that "we have not, as yet, any way of knowing which individual may become an alcoholic" seem to have a potent and arresting effect on intelligent young people. All of us have a responsibility, not only as professionals but as citizens for preventive work, which is, in essence, communication.

We need to say: Do you know that there are, by the most recent estimates, 6 million alcoholics in this country? Do you know that it is estimated that every alcoholic affects the lives of at least 4 other people so that at least 30 million people are damaged to some extent by the excessive use of alcohol? Do you know that there are between 1½ and 2 million women alcoholics? That many of these are mothers whose behavior has a probably more disruptive influence on the home and the emotional development of the children involved?

Complex Disease

We need to define alcoholism as a complex disease having physiological, psychological and sociological implications and to have it understood that although it is a chronic behavioral disorder manifested by drinking in excess of the social or dietary uses of the community to the extent that it interferes with the drinker's health, life expression and his social or economic functioning, it *is* treatable. Alcoholics *can* recover if they will participate in treatment.

We must make it known that that reputable organization, the American Medical Association, has recognized alcoholism as a disease entity and that influential men and organizations have come to realize that alcoholism is *immune* to punishment and sermonizing.

In communicating to the public, we have a responsibility to see that a clear differentiation can be made between acute intoxication and chronic alcoholism, between willful drunkenness and compulsive drinking. We should be able to convince those who need to know that diagnosis of alcoholism pivots on the concept of loss of control and that diagnosis alone does not bring about recovery. The diagnosis must be accepted and the individual become willing to reorganize his life on the basis of the diagnosis, as in the case of the diabetic, for example. He can live a normal, happy life under certain accepted limitations, and with proper treatment.

Four Phases

The various phases or stages of the disease should be communicated, so that individuals can be alert to the danger signals. Not everyone would agree, perhaps, with Dr. Jellinek's outline of these phases, but I find them particularly useful and they are incorporated in my intake form. This not only gives me a guide for logical questions and aids my own evaluation, but it serves to communicate to the other staff members who may see the patient about how far his involvement with alcohol has progressed. Since Dr. Jellinek's study is based on an analysis of the drinking histories of more than 2,000 alcohol addicts, his conclusions have more than passing interest for me and they are supported by my own observations in practice. He has divided the alcoholic's drinking into 4 phases: the pre-alcoholic, the prodromal, the crucial and the chronic. The first two he describes as purely symptomatic and the latter two as addictive. During each phase he notes certain behavorial symptoms that appear characteristic.

In the pre-alcoholic phase, the drinker finds more relief from tensions through the use of alcohol than does the social drinker. Having found what alcohol will do for him, he seeks this relief repeatedly, contrives to be where alcohol is available and his tolerance for alcohol increases.

The first unmistakable sign, for Jellinek, of the prodromal phase is the recurrent blackout: A slight temporary amnesia, at first, where there is a blank for a period in which something was said or done of which the drinker has to be reminded the next day. If it recurs with any regularity, it is meaningful. Typically, this is accompanied by surreptitious drinking, sneaking an extra drink while mixing drinks, having a few before going where drinks (but too few) will be served, and so on. About now alcohol may begin to cause the drinker some misgivings, some self-doubt.

Loss of control, as has been said, is the determinant. When the drinker experiences this, he is in the so-called crucial stage. Family and friends begin to express concern, he becomes defensive and begins to rationalize, to be hostile and aggressive, to project *and* to suffer extreme remorse, usually, when he sobers up. It is my own interpretation that it is at this point that his social isolation begins. He feels he should be rejected, becomes frightened and more defensive, invites rejection by refusing and denying need for help, etc., and gradually progresses to the feeling that everyone is against him, he does not need them, he tells them so or acts in such a way that he is actually rejected and he becomes socially isolated. If one can recognize this, be empathetic and communicate this with acceptance, it opens a door for which the patient has yearned and he responds. They are the loneliest people I know, and the most respon-

sive when rapport is established.

Dr. Jellinek notes that the patient tries going on the wagon or not taking a drink until a certain time of day and so on in this stage, in an effort to control the drinking that has become a personal concern to him. With each failure, his hostility increases and he creates situations that may cause him to lose his wife, his job or his friends because they are reacting to him. He may also at this time start to hide his liquor, protect his supply and at about this time he also ceases to eat properly and typically may be jailed or hospitalized. His sexual drive decreases and in line with the tendency to project, his hostility toward his wife increases. He may fantasy unfaithfulness on her part which increases his hostility even further, and further "justifies" his drinking. With an increased intake, he is often ill in the morning and takes "a hair of the dog"; soon he is into regular morning drinking.

This leads to continuing the second day and later into prolonged alcoholic bouts that invite the serious physical and mental involvements of the *chronic phase*. He has tremors, psychomotor inhibition such as being unable to write his name or lift a cup or glass to his mouth without the aid of alcohol, indefinable fears, a feeling of utter hopelessness, vague religious feelings and his rationalization fails. If he quits alcohol because he is too sick to drink any more or runs out of money, he may have delirium tremens. He has "hit bottom" and has no choice except for help, at this point, in many cases. In others, after reaching this point, some alcoholics seem to be able to accept this as the only way of life and become so-called "plateau drinkers", i. e., never entirely drunk, but never sober. Many of these are skid row alcoholics, which by the way, are a very small proportion, placed by some as low as only 10% of all alcoholics. Many skid row people are not alcoholics but social misfits and are better designated as homeless men. It is imperative that we remove the stigma and blot out the stereotype of the alcoholic as a degraded, disgusting drunkard and urge constructive action in the community.

To sum up, the alcoholic is a sick individual and we are dealing with not only a sick individual but with that individual in relation to his community. How his community responds to him before, during and after his illness is crucial. He can be treated and he can recover. He is worth helping as has been proven by the highly productive lives many recovered alcoholics live, no longer as liabilities but as great assets to their communities. We must recognize alcoholism as a major public health problem of epidemic proportions and accept our responsibility in dealing with it, not only as professional people, but as citizens. We must all work toward *integrating* the help of all the resources, forces and facilities in our community. We must enlist, offer and receive communication within that community. We must organize remedial measures, integrate services and have a unified approach if we are to be fully effective.

Finally, we must stimulate public opinion within the community to accept this as a problem and to feel responsibility for social action. A very first step toward all this is the complete assimilation of the fact that alcoholics are people like you and me, not a special and inferior breed of degenerates or a vicious type of moral weaklings. One out of sixteen drinkers is destined to become an alcoholic. It could be you or me or anyone we know; but education can be preventive, and we have a responsibility to communicate our knowledge *and attitudes* to our community.

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
615 Wills Forest Rd.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: AL 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: ED 3-5441 & ED 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland, Streets
WINSTON-SALEM , N. C.
Phone: PArk 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone DA 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-Patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: HE 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speaker—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Display—primarily for local public libaries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in **North Carolina.** For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

JAN.-FEB., 1959

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultatons with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a phychologist, social worker, a recreation director, an occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Executive Director

ROBERTA LYTLE, R.N., M.S.Sc.
Psychiatric Social Work Consultant

GEORGE ADAMS
Educational Director

INVENTORY

VOLUME VIII NUMBER 5

JANUARY-FEBRUARY, 1959

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices Old Health Bldg., Raleigh, North Carolina.

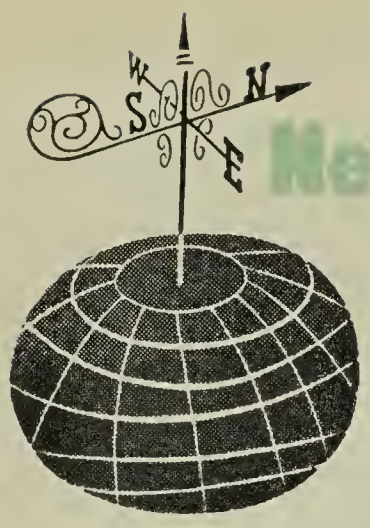
CLAIRE CHENEY
Editor

ELEANOR BROOKS
Circulation Manager

This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request. This journal will not be sent to persons other than those requesting it. Manuscripts invited with understanding that no fees can be paid.

Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.



News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

NEW YORK: According to a recent news release, Dr. Robert I. Levy says there is such a thing as the "alcoholic personality", contrary to growing doubt among scientists. Levy says the place to begin describing the structure of the alcoholic personality is at its foundation stones beneath the surface and not with any of the weird personality patterns which could be erected on those foundation stones. Those stones, according to Levy, are unconscious needs and if alcohol seems to lessen the problems which grow out of the needs, then you have the base of the alcoholic personality.

RALEIGH: The ARP will hold an Alcoholism Institute for Social Workers March 21, at the invitation of the Piedmont, N. C., Chapter of the National Association of Social Workers. The morning session will feature talks on "Team Process and Group Therapy in a Hospital-based Alcoholic Clinic". "Some Aspects of Therapy in a Home for Skid Row Alcoholics" will be the topic for discussion at the afternoon session. The Institute will be held on the campus of Wake Forest College, Winston-Salem.

CALIFORNIA: Although its only 1959, plans are already underway by General Service Headquarters of Alcoholics Anonymous for the 1960 World Convention, to be held at Long Beach, California. AA members from all parts of the world are expected to attend the convention.

FRANCE: A recent report in "The Christian Science Monitor" says that France has more alcoholism than any other country in Europe. The consumption of pure alcohol per capita per annum is not only the largest in continental Europe, but more than three times greater than in the so-called "hard liquor" countries—the British Isles and the U. S. Alcohol consumption is associated with 40% of all illnesses treated in French hospitals, bringing about 200,000 deaths a year. It also accounts, according to the article, for 57% of circulation accidents and 20% of occupational accidents. It is felt that steps will soon be taken by the French government to protect society from alcoholic abuse, although no prohibition is seen.

NEW HAVEN: The Publications Division of the Yale Center of Alcohol Studies has announced the publication of a new book, "Drinking and Intoxication: Selected Readings in Social Attitudes and Controls," edited by Raymond G. McCarthy, Associate Professor, Health Education, Yale University and Associate Director of the Yale Summer School of Alcohol Studies. The 500-page volume is published jointly with The Free Press of Glencoe, Ill. The book is a compilation from many sources of materials which bear directly on the attitudes toward drinking and drunkenness among different peoples of the world at different periods of history. Special attention is given to historical and contemporary drinking customs and attitudes in the United States.

SOUTHERN PINES: NCARP Committee Chairman, John Ruggles, of Southern Pines was recently named the 1958 recipient of the Sandhills Kiwanis Club Builders Cup for "longtime service to the upbuilding of the Sandhills without thought of personal gain." Congratulations to Mr. Ruggles for receiving this honor.

NEW HAVEN: The 1959 Summer School of Alcohol Studies will be held from June 28 through July 23, at Yale University. Application forms and a prospectus describing the course in detail and containing information on accommodations, fees, etc. are now available for distribution. This year special emphasis will be given to effective Public Health techniques in the field of alcoholism with the establishment of a Public Health Seminar. All applications for admission to the 1959 session must be submitted by March 15.

SOUTH AFRICA: An Information Center has been established by the Cape Peninsula society for Education on Alcoholism in Capetown. In addition, a Therapeutic Center for Alcoholics has just been opened at "Sans Souci", Newlands.

RALEIGH: Plans are now in the making for the 1959 Nurses' Institute in Alcoholism, held annually by the ARP in conjunction with the three state nurses' associations. The one-day Institute will be held in the spring and will feature outstanding speakers in the field of alcoholism treatment and education. Private, public health, industrial and institutional nurses will attend the Institute.

CHICAGO: The Committee on Alcoholism of the Council on Mental Health of the American Medical Association has recently published a Directory of State Resources on Alcoholism, which will be used by physicians. The Directory includes a listing of state government agencies concerned with alcoholism education and treatment, plus a listing of citizens' voluntary committees and of committees on alcoholism of state medical societies.

Has Deep Interest

Could you please place my name on your regular mailing list for your publications? I have a deep interest in this field of work and want to thank your organization for your labors in this field.

The Rev. Edward Laffman
Henderson, N. C.

Family Life Workshop

In our Family Life Education Workshop to be held in January, we would like to distribute kits of material to each person present. If you have any free leaflets or pamphlets on alcohol, please send them to me immediately. In our workshop, we are discussing emotional behavior and its relationship to the use of alcohol, broken homes and juvenile delinquency.

Mrs. Geneva J. Bowe, Supervisor
Hertford County Schools
Murfreesboro, N. C.

Wants Ministers' Guide

On February 27, there will be a seminar and workshop for the ministers and key laymen of 55 Methodist churches in Central Massachusetts. The subject under consideration will be "Rehabilitation of the Alcoholic". I discover you have an excellent piece of literature that we would like to feature on a literature table, "Alcoholics Are God's Children, Too". Can you arrange to send us 50 copies?

The Rev. James R. Uhlinger
Wesley Methodist Church
Worcester, Massachusetts

(*Ed. Note: There is a charge for quantity orders. Price list for all ARP literature available on request.*)

Thanks For Inventory

During my stay as the Commanding Officer of The Salvation Army Men's Social Service Center, whose program is built on rehabilitation of the alcoholic, I received the booklet, INVENTORY, which I found to be of valuable help. I am now located in Columbus, Ohio, and would like to be put on your mailing list again. In anticipation of your generous response, I would like to say "thank you."

Lloyd Smith, Major
The Salvation Army
Columbus, Ohio

From Al-Anon Member

Please put me on your mailing list for your magazine, INVENTORY. I have been told by the Al-Anon Group that this is a service which your department handles. If you have any other literature which you think might help me or be of any benefit to my husband, I would appreciate it very much if you would mail it to me. My husband is a recent member of AA and both of us are interested in anything which will help in our recovery.

Al-Anon Member
Burlington, N. C.

VOL. VIII, NO. 5 JANUARY-FEBRUARY, 1959

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

WHO... ME? NEUROTIC?

Uncontrolled drinking is just one of many symptoms that may develop when one is ruled by his emotions.

"THE nerve of that guy, telling me I'm neurotic. I'm not crazy. I just drink too much!"

The words might be spoken by almost any alcoholic. His resentment at even a suggestion of emotional illness is swift and intense. He misinterprets the term when applied to him, suspects that we have already reserved a room for him at the nearest mental institution. He reacts by angrily closing his mind and running for the nearest exit.

This is unfortunate, because alcoholism *is* a neurosis. The alcoholic is emotionally sick. But he may expend so much energy dodging the truth that he blocks his way to sobriety and effective living. He considers the stigma of emotional illness too great to bear, so he keeps circling his real problems, never getting any closer to their solution.

In this misconception, the alcoholic

only reflects attitudes widely held by the American public, of which he is a part. The great majority of people still believe mental or emotional illness is somehow much more disgusting and shameful than physical illness. To some extent this is a carry-over from primitive times when the mentally ill were thought to be inhabited by the gods or possessed by a devil. Today, of course, medical science knows they are legitimately sick people. Nevertheless, a large segment of the public still embraces superstition rather than truth.

To counteract the lingering stigma, the alcoholic should learn the facts about his neurosis. First, he must understand that he has a milder form of emotional illness than those patients who suffer from a *psychosis,* which often requires long-term hospitalization and intensive psychiatric therapies. His ailment is not nearly so severe, nor should it require lengthy confinement in an institution.

Plenty of Company

Neither can the neurotic alcoholic be set apart as a member of a minority unfit for normal society. It may surprise him to learn that he has plenty of company. Some doctors estimate the neurosis rate for Americans as high as 80 per cent. Others say it is nearer 50 to 60 per cent. So instead of pointing the finger of scorn at "those neurotics", Mr. Average Citizen might well change his concept to "us neurotics."

What do the neurotics have in common? How can we tell the difference between the sick and the well? This can best be explained by contrasting neurotic behavior with the so-called normal. In her book about alcoholism, Dr. Ruth Fox explains it this way: "The difference (between neurotic and normal) can be likened to that between freedom and slavery. If, in the face of a given situation, you react flexibly, responding to the situation's realities, learning from experience, then you are healthy, at least in relation to such a situation. If, on the other hand, you react always in the same way, never adapting, never changing, never learning from experience, if your response is in a fixed pattern no matter what the situation's realities, then you are in trouble."

Very similarly, Dr. Smiley Blanton, psychiatrist, explains the difference between the neurotic and the normal as that between *rigidity* and *flexibility* of emotional reactions.

The Rigid Reaction

Suppose we express the difference in terms of everyday experience. A salesman, for example, gets a nasty rebuff to his sales proposition from an affluent customer. He is not only turned down flat but his business judgment as well as the quality of his product is insulted by the hot-tempered businessman. If he is an emotionally healthy person, the salesman may react in any number of different ways. Perhaps he will decide to defend himself and his product in a logical and calm way, or else to say nothing at all until the customer calms down. It may seem best to overlook the whole affair, to smile and make a graceful exit, or even to take the customer to task for his unreasonableness. His emotions may reflect calm, anger, detachment, amusement or any number of other reactions. The healthy person can sift through all these emotional reactions and pick out an appropriate one to fit the situation. He is *free* to choose.

What would the neurotic do in the same circumstances? Inside, he might experience some of the same feelings

at being rebuffed as the normal person did. But if you knew him, you could predict almost infallibly what his reaction would be. Suppose he becomes very angry, blows up at the customer and insults him in return. There are times, of course, after all other alternative reactions have been explored, when anger is appropriate. But the point is, the neurotic would not be able consciously to choose his reaction as did the healthy person. In the neurotic, the emotional response just pops out before he even realizes what has happened. And, equally important, it will always be the same type of response. Instead of being master of his emotions, the neurotic is enslaved by them.

We can be sure that the neurotic salesman's rigid reaction pattern would get him into trouble. He would probably lose his job for alienating a good customer. The curious thing is that he would not be able to profit by his experience. If he got another position, the first balky customer he encountered would elicit the same emotional response that lost him the previous job. He'd be fired again, again and again. But he is powerless to control his emotions.

The neurotic may realize intellectually that his rigid behavior gets him into trouble. But mere recognition will not enable him to change his response to suit the occasion. He literally cannot do otherwise, since he is ruled by emotional forces which are outside his consciousness.

Now, we can begin to see how the alcoholic fits into this picture of neurotic behavior. Recall that an alcoholic has been described as a person whose drinking is compulsive and uncontrolled, eventuating in damage to every area of his life—health, family, job, church, social, etc. The question is, why does he keep on drinking after the damage has already set in? How many perplexed and anguished loved ones have asked, "Why do you keep on drinking, Joe, when you know it's ruining you and us, too?"

To go back to our neurotic salesman for a moment. Why would he give vent to his anger when he knew very well it would get him into trouble time and time again? The answer is, he was ruled by emotional forces over which he had no control. And so is the alcoholic. They are brothers under the skin. Even though the one may never have had a drink, nor the other have ever lost his temper.

The alcoholic has developed his own special way of reacting to stressful situations. He runs for the bottle, gets drunk. He has no more control over this reaction than does the salesman over his temper outburst. He is suddenly overwhelmed by his emotions. This is the common denominator of neurosis.

The neurotic is not condemned to emotional slavery for the rest of his day. He can change. His emotional ailment can be treated, arrested and, in many cases, cured completely. The process is not as easy, of course, as getting a shot of penicillin in the doctor's office. It requires something of the patient—a deep desire to get well, plus a willingness to discover the truth about oneself. But the treatment can be very rewarding. The neurotic can regain mastery of his emotions.

If drinking is your symptom, we hope you will no longer be ashamed of being a member of the neurotic majority. Remember, you have plenty of fellow sufferers. And you can recover your health if you really want to badly enough.

"By the way, will you hand me my bottle of tranquilizers on your way out? I've got another one of my sick headaches!"—G.H.A.

What happens when a seemingly normal social drinker becomes a person to whom alcohol is the beginning and the end—a compulsive drinker who tries to hide behind the bottle?

THE NORMAL AND ABNORMAL DRINKER

From ALCOHOL: ONE MAN'S MEAT, by Edward A. Strecker, A.M., M.D., Sc.D., and Francis T. Chambers, Jr. Copyright 1938, by The Macmillan Company. Reprinted by permission.

THE term "normal drinker" is not paradoxical. If he is normal, he presents a picture of a convival drinker who uses alcohol as a socially acceptable gesture and never gets into serious trouble from its use. His drinking is done solely to bring about a state of mind in which his thought processess are less strictly inhibited. He gains freedom from the conformity to the behavior demanded by maturity and is, therefore, more childlike and naive. He cajoles his subjective self in some such fashion as this: "Let's make believe that life is all happiness, and I, with a few cocktails under my belt, am one of the most contented, charming, and intelligent members of my group. The fact that I have a wart on my misshapen nose is more than compensated for by intelligence and charm." This Utopia vanishes with sobriety, and though the sober personality is painfully aware of the wart on the nose and keenly realizes that he is woefully lacking in the charm and intelligence he craves, he neverthless accepts the reality of sobriety because he is, in fact, well adjusted to it. We may sum up the normal, controlled user of alcohol by saying he drinks to exaggerate reality because he finds reality enjoyable.

The borderline between normal and abnormal drinking is crossed when a man attempts to use alcohol as an aid to adjust himself to reality. The first symptoms of this dangerous and abnormal use of alcohol may be transitory or may be the beginning of an eventual slavish dependency. Early danger signals are flown in various ways. For instance, we notice that the conversation of one of our friends, whom we have always considered a normal, well-behaved and reserved person, becomes embarrassingly indecent after a few drinks. Another friend, ordinarily modest and retiring, becomes extremely boastful under the same condition. Occasionally we see someone who is usually friendly and gregarious suddenly become rude and gauche after he has had a few highballs. In the peculiarities of these reactions, we believe that there is revealed a glimpse of the attempt of the ego to compensate for certain conflicts not acceptable to the ego ideal of the individual. It is as if the intoxicated person unconsciously knew that by narcotizing the higher nervous centers, too much of the inner man would be revealed to the judgment of his fellows, and so he attempts to compensate for deficiencies of personality, normally unad-

mitted, even to himself. Sometimes the conversation of a drinker, who becomes embarrassingly indecent, may lead you to suspect that he is suffering from a sex complex, for it is true that the unfortunate who attempts to convey the impression of potency is usually insecure in his own feelings of sexual adequacy. The boaster who brags of his prowess in the business world when he has "drink taken" is insecure in his innermost feelings about his ability, and is endeavoring to reassure both you and himself. The man who becomes rude and gauche is merely trying to hide his social insecurity by attacking first, because he constantly fears that a social offensive may be launched against him. Thus, one of the hazards of alcohol is that without conscious deliberation it may be readily applied as a salve, which in the beginning, at least, acts magically in soothing the painful wounds of personal belittlement and insignificance.

In this connection, we must not accept the old adage, "in vino veritas", too literally, as it would require a trained psychotherapist to analyze the drunken babble of many alcoholized persons. Addison observed carefully in order to write that alcohol "displays every little spot of the soul in its utmost deformity," but this does not necessarily mean that the soul of the alcoholic is more spotted than other souls. It does mean that alcohol is the great Uninhibitor and releases material from depths which otherwise would never have reached the surface. What we must accept in the individual whose drinking has become a problem to his friends, his family, and himself is that he is undoubtedly tending to use alcohol for its psychological compensatory power as an escape from, rather than as an exaggeration of, reality. Whether such a person is definitely recognized as a chronic alcoholic, or as a bad actor or an ineffective worker, because of the use of alcohol, makes little difference in the ultimate seriousness of his problem. In any event, abnormal drinking, if it continues, reveals a state of mind which the drinker himself regards as unendurable. In other words, he is suffering from a type of "nervous breakdown" and is using alcohol to alleviate an intolerable mental condition.

Not Easily Deceived

Those who know little of the psychology of alcoholism are easily deceived by the camouflage which the alcoholic unconsciously uses to disguise his inner conflicts. It is true that many abnormal drinkers have, in their actual circumstances, a good excuse for employing the escape mechanism offered by alcohol. However, it is rare to find the real underlying cause of an addiction entirely contained in the immediate environment. When we question our patients, they either do not know why they use alcohol abnormally, or they attempt to rationalize the use of it. In approaching these patients, we must take our cue from the psychotherapists who have led their neurotic patients suffering from neurasthenia, or anxiety states, or hysteria, or compulsion neuroses, back to the normal planes of life. They do not tell the patient who has taken to her bed, because she believes she has cancer, that it is all foolishness. They recognize that there is a very serious disorder of function, that to the patient it is just as real and painful as the actual disease. They base treatment on the analysis of the initial conflict that caused the patient to accept the tribulations of a functional disorder rather than to face a state of mental conflict. The "cancer" may presage an inability to

face openly in consciousness the infidelity of the husband.

The pictures that present themselves in our clinic vary from those who are not even suspected by their contemporaries of being abnormal drinkers to others whose trouble, no one can doubt, has to do with alcohol and plenty of it. In a group of unevident abnormal drinkers, we usually find that the condition has been disguised from the world by the connivance of the family who dread the stigma that would be attached to the spreading of the knowledge that a son, brother, husband, or wife is psychologically dependent on alcohol. Such a precarious status of protection may persist for a long time, the periods of abnormal drinking being explained away under the heading of some "nervous" or other illness. In such cases, unwise families are aiding and abetting a condition which they are too proud to face frankly and honestly, and as the progress of the disorder invariably brings it to the light of society in a conspicuous fashion, they have accomplished nothing of a beneficial nature and usually they have done a great deal of harm. From the top of the ladder of social approval down to the last rung of social condemnation, we may expect to find the condition of abnormal drinking.

Symptoms are evident in those who refuse to face any phase of reality without recourse to alcohol. These are the men and women who must start drinking for "courage" to face the day, and must continue to drink in order to "carry on" through the day. Just because they can refrain from using alcohol for varying lengths of time after the distress of an alcoholic breakdown that demanded medical care and supervision is no reason for them or their friends to think they can again drink in moderation. Popular belief to the contrary, the worst drunkards often go "on the wagon" for surprisingly long periods of time. This is not so remarkable when one takes into consideration the tremendous immediate incentive produced by the distress of the last relapse.

A less obvious, but equally serious type of abnormal drinker ,is one whose behavior becomes unsocial as soon as he starts to drink. Though his friends may excuse his conduct as only being caused by intoxication, he is, generally speaking, an increasingly annoying nuisance and bore, as well as an embarrassment at social gatherings. In young men such symptoms, when they are quite frequent and critical, usually herald the condition of definitely abnormal drinking. The semi-invalid type is usually a narcissistic individual whose personality refuses to permit the out-and-out earmarks of drunkenness. Consequently, he lives a Dr. Jekyll and Mr. Hyde existence, presenting to his environment the picture of semi-invalid drinking in a controlled manner, only to unleash deeper addiction in the privacy of his home. Eventually, he, too, is "caught out" because of the progressive abnormality of his drinking. Sooner or later the excessive drinker with the least shred of intelligence is forced to face the fact that his drinking is abnormal, and this is the crucial psychological moment when he really has a chance of absorbing and applying the re-education that is necessary to permit him to lead an adequate non-alcoholic existence. The self-diagnosed drunkard is always the one about whom we are optimistic.

In summing up, we can say that the abnormal drinker is the man who cannot face reality without alcohol, and whose adequate adjustment to reality is impossible as long as he uses alcohol.

UNDERSTANDING ACCEPTANCE

THE ALCOHOLIC'S GREATEST NEEDS

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A broad discussion of causes and treatment of alcoholism — for the therapist and lay person.

THERE is no group of persons which is more in need of greater understanding and acceptance as being ill than alcoholics. It is generally accepted that there are probably well over four million persons in the United States in whom drinking has a sufficiently adverse effect on their lives for them to be considered as problem drinkers.

Over twelve thousand alcoholics die each year from chronic alcoholism. Even these few startling figures do not even begin to tell the story of the tragic ramifications of this illness. Five out of six alcoholics are men between the ages of thirty and fifty-five, their most productive years, the years when they are head of a household and the years when the family is most dependent upon them.

In addition to the untold personal suffering of the alcoholic himself, this suffering is magnified manifold in the lives of those close to him. In addition, the resulting loss of job, loss of a responsible tax paying citizen of the community and the resulting dependency of his family creates quite a financial burden to the community, aside from the humanitarian aspects of such a tragedy. Indeed, the problem is so great as to be considered the fourth major public health problem of our day.

Acute alcoholism is a toxic condition that results from a high concentration of alcohol in the blood stream. Usually accompanying acute alcohol-

ism in the chronic alcoholic are the effects of concomitant diseases that have developed as the result of the long history of drinking with poor eating habits and general neglect of one's physical condition. Common are such conditions as poly-neuritis, pellagra, ataxia, cirrhosis of the liver, nutritional heart disease, mental abnormalities, and many times, as the result of long years of drinking with marked neglect of dietary habits, we may find actual mental deterioration with organic brain damage and on occasion frank psychoses. Since the treatment of acute alcoholism is largely a medical problem, we will not go into details here except to remark again that acute alcoholism is an episodic toxic state occurring frequently in chronic alcoholics so that when we are discussing chronic alcoholics we are still talking about one and same person.

A Complex Illness

By chronic alcoholism we are referring to an illness that may be characterized as a form of addiction. The chronic alcoholic is a compulsive drinker. Without treatment and help he is unable to stop his drinking. It is not just a matter of will, but is a matter of a complex illness. The term chronic alcoholism denotes the group of physical and psychological changes that result from prolonged, excessive use of alcoholic beverages. Actually, alcoholism itself starts off as a symptom, usually of a personality disturbance, but the symptom itself with all its complexity and resulting difficulties and effects on the person becomes an illness. Alcohol does not in itself produce alcoholism. As one very pat phrase puts it, "The problem is in the man and not in the bottle."

The etiology of alcoholism remains somewhat obscure. It is known that only one out of fifteen drinkers ever becomes an alcoholic, that is, only one out of fifteen ever becomes a compulsive drinker to the point where alcohol becomes a serious problem in his life. Although there have been many intensive studies, no clear-cut organic basis has been proven for the development of alcoholism.

A Combination of Factors

The actual cause as such seems to lie in emotional factors resulting in a personality disturbance. In other words, alcoholism may be looked upon as a psychosomatic illness; that is, there is a combination of both organic and emotional factors. Given an individual with an as yet unknown organic factor that makes him a potential candidate for the development of alcoholism, plus a combination of emotional factors which have placed great stress upon this individual, plus in turn a culture that accepts the use of alcohol as a means of alleviating emotional problems and anxiety, we have the possibility of developing a chronic alcoholic. This, perhaps, sounds rather complex but actually it is no more complex than the series of factors that seem to be involved in most of our illnesses even though they seem to be more clearly organically based. More and more we are finding that most illnesses are a combination of potentiality within the individual for developing such an illness, exposure to the traumatic agent whether it is bacteria, emotional forces, changes in weather, or whatever, plus a favorable environmental situation or culture for the disease process itself to develop in.

Psychogenic factors are an important element in the development of chronic alcoholism. However, there is no one typical alcoholic personality although certain common factors have been distinguished in research

studies. As one reviews case histories in large numbers, it is common to find evidence of emotional frustration, unmet dependency needs, failure to establish independence from a dominant parental figure and the subsequent resentment. A lack of ability in childhood to satisfy parental demands and the consequent rejection may initiate feelings of inadequacy and guilt. Many chronic alcoholics apparently develop oversensitivity and an inability to solve conflicting inner drives. Fairly common are difficulties in the phychosexual sphere. Paranoid trends are also often in evidence. The chronic alcoholic seems basically to want to maintain a more or less passive-dependent type of existence. In addition the alcoholic often refuses to recognize his limitations and, therefore, constantly subjects himself to emotionally hazardous situations that can only result in more anxiety and tension.

Not Immorality

All this, of course, has many implications for the treatment of alcoholism. It is important that alcoholism be recognized as a psychic illness, rooted in a personality disorder or emotional immaturity and not be regarded as a moral problem. In addition to the general medical care indicated, the patient needs help in reviewing and understanding his experiences and emotional reactions to discover those factors which have caused him to become dependent on alcohol. One of the goals of therapy is not restraining the alcoholic from drinking but rather is in helping the patient in such a way that he no longer desires alcohol as a means of relieving his anxiety and tensions.

I want to spend a few minutes talking with you about the relationships of cultural attitudes and therapy; whether the therapist is a psychiatrist, a social worker, a nurse, a family physician, a clergyman, or whatever—will it or not—any person establishing a significant relationship with an alcoholic becomes in many senses of the word, a therapist. Perhaps the therapy may be harmful rather than beneficial but in any event this relationship has some effect on the alcoholic and his problems and thus deserves close evaluation.

The Influence of Culture

None of us was born in or developed in a vacuum. We are all products of a culture. We work in a culture with all its pressures, attitudes, values, distortions; we continue to remain a part of this culture and never become completely apart from or completely independent of it regardless of our training or knowledge. All too frequently, unfortunately, the general attitude existing in the culture of most of our communities towards the alcoholic is one of rejection and hostility. So often, the feeling is one that alcoholism is merely a matter of will, that if the alcoholic wanted to stop drinking he could but he just doesn't want to, therefore, why bother with him. Unconsciously, we also adhere to this underlying attitude of hostility and rejection, even though because of our intellectual and technical sophistication we have managed in a sense to suppress it and disguise these feelings so that they really come to the surface only under periods of considerable stress in working with the alcoholic. In addition, in working with alcoholic patients, their extreme dependence oftentimes threatens us. This relationship seems to ask too much of us. It seems to enmesh us—enmesh us in the alcoholic's problems to the point where we get very much concerned and anxious in our relationships with him. This, in turn, may

marshal all sorts of defenses and resistances within us that lead to rejection of the alcoholic. This rejection is expressed in rationalizations that really reflect cultural attitudes. Only, of course, because of our knowledge and training, we are much more subtle in our rejections and hostilities and are able to disguise these attitudes, more often than not, even from ourselves.

Then too, there is the other side of the coin. We throw ourselves completely into a case, give the patient everything that we have, establish a good strong relationship with the patient—and he seems to get along better and better—and feed our ego more and more because of the strong dependency relationship. Soon we begin to feel that we are really a hotshot therapist and we are actually delighted to have the alcoholic come back again and again for his therapy. Then suddenly, very unexpectedly, and like a bolt out of the blue, the patient slips with one grand and glorious binge! What a blow this is! Not to the patient but to us. How could he do this to us? How could he undo everything that we have done for him? How could he be so ungrateful—and on and on and on? The patient is completely lost sight of as we struggle with our own wounded professional egos. What a blow! Not only has he proven unworthy of the tremendous emotional investment we have put into our relationship with him (and it becomes difficult to work with alcoholics without making an emotional investment) but he has shattered our beautiful concept of ourselves as the great therapist and our professional egos find it hard to take without some resentment and hostility creeping in toward the one who has done this to us.

Of course, with academic and technical sophistication, one becomes much more subtle in giving expression to hostility and rejection; in fact, one can even hide it from oneself. But no matter how subtle, no matter how disguised, patients unfortunately can sense rejection and hostility, in any form. In fact, patients suffering from alcoholism seem to have supersensitive antennae for that sort of thing. Thus, no matter how technically and intellectually sophisticated we may be, when one has a personal investment in therapy (and again it is difficult not to have such an investment in working with alcoholics) traumatic blows to our ego tend to bring about marked emotional responses in ourselves that reawaken all the cultural attitudes that we think we have gotten rid of, in such a way as to even fool ourselves. Thus, we must always be constantly on the alert for this possibility within ourselves and be willing to always turn the search light upon ourselves as well as upon our patients.

Several Pointers

It is important in working with alcoholics to keep several things in mind in order to maintain one's effectiveness:

1. *Be aware of the natural history of the disease.* Alcoholism responds slowly to treatment. The course of recovery is marked by many relapses, failures, and frustrations. This is to be expected and it is important to get over to the patient the fact that you are not disappointed, surprised, shocked or angered at his relapses but that you are calmly confident that this may happen and that the patient may continue to progress even in the face of such relapses. At the same time, one certainly is not to give the impression that one condones this continued retreat to the use of alcohol as a means of handling anxieties and tensions.

2. It is important that the therapist

(Continued on page 31)

What the Experts sa

Honest, up-to-date answers to frequently asked questions, supplied by experienced professionals.

What is alcoholism?

Alcoholism is a chronic behavioral disorder manifested by repeated drinking of alcoholic beverages in excess of the dietary and social uses of the community and to an extent that interferes with the drinker's health or his social or economic functioning. *Mark Keller in "Alcoholism: Nature and Extent of the Problem."*

How many alcoholics are there in the U. S.?

There has been no nationwide census and none is in sight, though there have been a few significant local surveys . . . Estimated by the Jellinek formula in 1955 there were 4,712,000 alcoholics in the United States—4,002,000 men and 710,000 women . . . Only a small part will be found on Skid Row. Alcoholics may be discovered in every stratum of the population, and it has been estimated that more than 1,650,000 are employed in business and industry. *Mark Keller in "Alcoholism: Nature and Extent of the Problem."*

What is the metabolism of alcohol?"

The metabolism of alcohol refers to its fate in the body. On imbibing alcohol its effect is exercised only after it is absorbed. Absorption refers to its passage through the walls of the alimentary tract into the tissues and fluids of the body. Unlike most foods, alcohol requires no digestion before it can be absorbed. However, since the function of the stomach is mainly that of digestion, alcohol like most other ingested substances must pass into the small intestines in order to be rapidly and completely absorbed. It is only the alcohol which is absorbed and carried by the circulating blood to the brain that exercises an intoxicating effect . . . The speed with which the alcohol leaves the stomach, and therefore the rate of absorption, depends on the amount of food in the stomach, on the kind of beverage drunk, and on individual constitutional factors. *Leon A. Greenberg, PhD., in "Intoxication and Alcoholism: Physiological Factors."*

What can a drinker of alcoholic beverages do to help speed the "sobering up" process?

Some way of hastening the disappearance of alcohol from the body and thus diminishing intoxication has been sought for widely; the efforts have been unrewarded. Many drugs which greatly increase bodily

About ALCOHOLISM

Answers are based on a collection of articles by different authors, appearing in THE ANNALS OF THE AMERICAN ACADEMY OF POLITICAL AND SOCIAL SCIENCE, Volume 315, 1958.

metabolism and oxidation of other foods have no effect on the rate of alcohol oxidation; nor is the inhalation of oxygen effective. The common belief that alcohol can be disposed of and intoxication "worked off" by exercise has no basis except to the extent that exercise takes time. And sobering up is a matter of time that just might as well be spent in relaxation. Stimulant drugs may counteract some of the depressant actions of alcohol, altering behavior. Such changes are not uncommonly interpreted as sobering. Thus the inebriate, frequently prone to fall asleep, is stimulated by the caffeine in the "black coffee"; he is now merely a wide-awake drunk instead of a sleepy one. *Leon A. Greenberg, Ph.D., in "Intoxication and Alcoholism: Physiological Factors."*

Is it not true that alcoholism is on the increase?

In the past fifteen years attempts by families to conceal alcoholic disorders have become less common and less intense . . . Thus the apparent rise in the rate of alcoholism may only reflect franker and more complete medical reporting . . . This would mean that the most recent rates reflect a truer picture of the situation than those of the past. If the rates should now tend to flatten out, it may mean that reports have finally caught up with reality, or even that the rate of alcoholism has begun to decline. *Mark Keller in "Alcoholism: Nature and Extent of the Problem."*

Is alcoholism among women on the increase?

In the United States, the male to female ratio of alcoholism is about 5.5 to 1 . . . In actual numbers, . . . about three-fourths of a million to a million (alcoholics) are women . . . Recently there have been several assertions that alcoholism is markedly on the rise among women. While there may well be a small, genuine increase, the available statistical information does not show a sudden, sharp dramatic rise over the last two decades . . . It is probably wisest to assume at this point that alcoholism in women has increased over the last two decades and that this increase is small. *Edith Lisansky, Ph.D., in "The Woman Alcoholic."*

What are the physical causes of alcoholism?

Needless to say, the alcoholic is sick

—sick physiologically as well as emotionally and socially . . . Alcoholism is indeed a complex phenomenon involving both in its origin and manifestations subtle and devious interplay of physiological, psychological, and social factors . . . In fact, present knowledge of physiology offers no certain answer as to the cause. But to deny entirely a physiological etiology would be to deny psychosomatic concepts. When we have learned the physiology of thought, emotion, motivation, and social behavior, then will we, perhaps, know the physiological etiology of alcoholism. *Leon A. Greenberg, Ph.D., in "Intoxication and Alcoholism; Physiological Factors."*

Why does the woman alcoholic have more social stigma attached to her illness than her male counterpart?

Alcoholism in women is more disturbing because it represents the breaking of stronger taboos against drinking and intoxication in women, because it runs so strongly counter to the American ideal of self-controlled, "ladylike" behavior, and because it probably produces even greater disruption in family life than alcoholism in men. But the first step in examining this problem is to recognize that we are more likely to sit in judgment on the woman alcoholic than on the male alcoholic. This double standard attitude exists, to a greater or lesser extent, in all of us and we need to be aware of it. *Edith Lisansky, Ph.D., in "The Woman Alcoholic."*

Is alcohol a stimulant?

Despite such enthusiastic assertions that alcohol serves as a stimulant to mental functioning, the weight of evidence points clearly to the conclusion that alcohol, far from being a stimulant, actually serves to depress most psychological functions. It has been found . . . that alcohol . . depresses the sexual reflexes, in large doses completely abolishing them . . . increases reaction time . . . lowers the threshold at which sensory stimulation can be perceived—notably in the field of vision—it also impairs the individual's ability to discriminate sights, sounds, and tactile sensations to a considerable degree. Alcohol also affects the ability to estimate time . . . it produces memory losses, impairment of learning ability, and relative impoverishment of thought content . . . Alcohol is basically an anesthetic. *John J. Conger, Ph.D., in "Perception, Learning and Emotion: The Role of Alcohol."*

How does the alcoholic's drinking affect those around him?

. . . It can be estimated that for each alcoholic there are at least two people in the immediate family who are affected. Approximately two-thirds of the married alcoholics have children, thus averaging two apiece. Family studies indicate that a minimum of one other relative is also directly involved. The importance of understanding the problems faced by the families of alcoholics is obvious from these figures. To date, little is known about the nature of the effects of living with or having lived with an alcoholic. However, there is considerable evidence that it has disturbing effects on the personalities of family members . . . It is now believed that the most successful treatment of alcoholism involves helping both the alcoholic and those members of his family who are directly involved in

his drinking behavior. *Joan K. Jackson, Ph.D., in "Alcoholism and the Family."*

What effect does the alcoholic parent's drinking have on his children?

The children are affected by living with an alcoholic more than any other family member . . . Almost inevitably his parents behave inconsistently toward him . . . The nonalcoholic parent attempts to play the roles of both father and mother, often failing to do either well . . . If the child tries to stay close to both parents, he is caught in an impossible situation. Each parent resents the affection the other receives while demanding that the child show affection to both . . . The children do not understand what is happening . . . They hesitate to bring their friends to a home where their parent is likely to be drunk . . . Even those who are not ostracized becomes isolated . . . Unfortunately we still know very little about what happens to the children or about the duration of the effects. *Joan K. Jackson, Ph.D., in "Alcoholism and the Family."*

Why does one person become an alcoholic when another person is satisfied to drink only moderately?

Some individuals are better equipped than others by heredity and environment to cope with their conflicts and problems. How an individual faces and handles his inner problems and the problems of his environment, what conflicts arise, and what specific methods are used to solve them influence and determine his character, maturity and social adjustment. The exact nature of the alcoholic's conflicts and problems has been the subject of much discussion and research. Are they unique, more unique, more intense, or is the alcoholic just not equipped to handle his day-to-day problems? These questions are some of the riddles of the alcoholic sphinx . . . To date, no one theory either organic, psychological, or sociocultural completely explains the alcoholic addiction. *Sidney Vogel, M.D., in "Psychiatric Treatment of Alcoholism."*

What is the aim of psychotherapy in treating the alcoholic?

The immediate aim of therapy is sobriety and the long term goal is a resynthesis of life without dependence on alcohol. The alcoholic must learn and accept in a deep and thorough sense that he does not have the choice of temperate or social drinking. The admission of impotence in the face of alcohol, or "surrender" as described by Tiebout is a *sine qua non* for the successful arrest of the illness. This is not easily achieved for the problems that fostered drinking are threatening in sobriety, and the urge to find relief through the quick acting agent — alcohol — is strong and unfortunately, too often, overwhelming . . . A constructive substructive substitute for alcohol must be found. This is a slow, painful and undramatic process. It demands a radical change in their way of living, new interests and attitudes, new friends or new ways of relating to old friends, and new ways of coping with difficulties. The purpose of psychotherapy is to help the patient understand his problems, realize his potentialities, and through this, find a substitutive way of life. *Sidney Vogel, M.D., in "Psychiatric Treatment of Alcoholism."*

THE PROBLEM DRINKER AS INDUSTRY SEES HIM

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SCOVILL MANUFACTURING COMPANY
WATERBURY, CONNECTICUT

Reprinted from ALCOHOLISM AS A MENTAL PROBLEM IN BUSINESS AND INDUSTRY, proceedings of a workshop sponsored by the Rhode Island Division of Alcoholism under a grant from the National Institute of Mental Health.

INDUSTRY has looked at the problem drinker ever since industry began—for like the poor, the problem drinker is ever with us. Industry has looked at him, sometimes askance, very rarely in true perspective, and usually with both eyes tightly shut. For many years, industry, like the proverbial ostrich, buried its head in the sands, and convinced itself that there was no such thing as an alcohol problem.

Supervision, of course, knew that problem drinkers were on the payroll. During periods of ordinary employment screening, coupled with careful and thorough medical examinations, frequently detected the alcoholic flaw in the prospective employee and usually resulted in rejection.

Number Boosted

However, periods of high employment, especially during the war years when the skillful, dependable young men of industry joined the Armed Forces and were partially replaced with many of these previously rejected applicants, boosted the number of problem drinkers in our factories to such an extent that supervision had difficulty in maintaning production schedules, quality standards, and departmental discipline.

HOW DID SUPERVISION HANDLE THIS SITUATION? Treatment of the problem drinker differed, depending upon the whim of the individual supervisor. The usual procedure was to "cover" the alcoholic. Should he appear at the factory gates in an intoxicated condition, the guard would stop him, order a cab, send the man home, and report him in as "sick."

Should the problem drinker appear in his department, either loaded or overloaded, the same procedure would be followed, in fact, in some companies a "sleep it off" area was an unauthorized but standard departmental facility. In almost every case the problem drinker was a friendly, hard working (when sober) family man, liked by everyone. To discharge such an employee for alcoholic offenses was a most disagreeable task. So supervision devised a dodge. When the drinker really became an insolvable problem, the supervisor would then recommend him as a fine worker to another department in need of additional work force. A transfer would be arranged and the problem drinker found himself in a new department with a new boss.

In due time the transfer procedure would be repeated until finally industry ended up with an employee with many years seniority and a drinking problem that seriously impaired his usefulness. Yet in all those years no mention was made of his drinking. He was just "a nice guy who was sick a lot". No wonder industry in general felt that there was no alcohol problem in their plant!

What caused industry to take a closer look at the problem drinker and to see him in a more realistic setting—with its resultant effective and radically different treatment?

What caused industry with its supposed hard-hearted outlook on life and with its self proclaimed primary motive for existence, the making of a legitimate profit, to extend its hand and its facilities to help the problem drinker rehabilitate himself to sobriety?

Pioneering Spirit

Major credit for this change in attitude and procedure is due to the pioneering spirit and the unstinting devotion of a small group of farsighted educators, who established at New Haven, Connecticut, the Yale Center of Alcohol Studies and I would like to pay special tribute to the memory of the one man who has

contributed more to the advanced technique in the treatment of the industrial problem drinker than any other man I know. I refer to the late Ralph M. (Lefty) Henderson, who served as Industrial Consultant for the Yale Center and whose recent death is mourned everywhere.

It was his personal conviction, his dynamic drive, and his all embracing personality that blazed a trail through the industrial world and mapped out a pattern that established new understanding of the problems and trials and tribulations of the problem drinker in industry, a pattern, incidentally, based upon his own personal experience.

New Experiment

To the everlasting credit of American business, representative companies were ready to join in this new experiment, and DuPont, Allis Chalmers, Con Edison, and many others established their Alcohol Procedures in a new effort to assist their employees in regaining their sobriety.

What specifically is industry's problem in this matter of compulsive drinking?

Our basic problem is twofold:

1. With the employee, who because of his personal behavior, his excessive absenteeism, his poor work performance, and sometimes by his own admission is a clear-cut case of problem drinking and therefore ordinarily subject to disciplinary punishment.
2. With the employee, who at the moment is a problem to himself, only his behavior is still acceptable, his work performance is still passable, his absenteeism is no worse than average; yet in time his drinking problems will become supervisions' headaches too.

Can industry create a successful program that will effectively assist both groups? If so, what is required to develop and present such a program?

The first step is to indoctrinate top management. We must "sell top management first"—by presenting an educational and informative program for all top management personnel, in order that a basic general understanding and agreement will be created on such key questions as: "What is a problem drinker?" "Who and what is affected by problem drinking?" "What in-plant facilities are already available to aid in the control and prevention of alcoholism?"

The main purpose of the first step is to provide a common managerial understanding of the problem of both the problem drinker and those directly and indirectly affected by his actions and the need of and necessity for a formal program for control and prevention of problem drinking.

Second Step

Having this accomplished, the second step is now taken. Maximum efficiency of program function requires complete cooperation and understanding from every employee. Management will therefore initiate the second step by inviting top union officials to a presentation meeting. "Labor-management" mutual sponsorship is essential for the success of an Alcohol Program. A flexible statement of procedure should be issued,—presenting the aims and objectives of the proposed plan.

This done; we are now ready for Step No. 3. This statement of procedure together with necessary details is presented for general discussion and constructive criticism to groups of supervision, divisional stewards, and shop committee members. These groups will not exceed eighteen

members each and should not be less than twelve. Proper penetration may require two or three conferences for each group.

Step No. 4 then calls for an explanatory mass meeting, attended by all room improvement committee members and departmental stewards, addressed by both management and labor representatives, followed by a question and answer period.

Step No. 5 then is the plan presentation to the "rank and file" through the media of the plant newspaper, the bulletin board, house mail, etc. With supervision and union leaders already with the plan, an immense informative source is available to answer questions.

Plan Defined

What about the plan, its basic application and its progression?

The plan itself is squarely placed on the company's announced policy that "no employee will be discharged solely for alcoholic offenses, but will be referred to Alcoholic Procedure."

When it has been definitely established that frequent absenteeism and /or unsatisfactory work or behavior performance are caused by problem drinking, the foreman will refer the employee to "Medical". A confidential interview between employee and plant physician will determine the next step. A plant counselor, properly trained and who has a personal sympathetic understanding of the problem drinker will be at the disposal of "Medical."

He will at the request of "Medical" make all necessary "in-plant" and "out-plant" contacts and will have access to the services of such "in-plant" facilities as legal, social, recreation, credit union, employment office, etc. He will be thoroughly familiar with the "out-plant" facilities such as private and social agencies, clinics, hospitals, A. A. organizations, Police Department, clergy, courts, and the like. The plant counselor will report to "Medical"—"Medical" will report, when necessary, to the foreman.

What about negative cases?

Non-cooperatives will be required, as a matter of employment, to appear before the Review Committee, which will consist of a representative of "Medical" (including plant counselor), Personnel Department, Management and Union (representing the Community Service Committee except, of course, when the problem drinker is in the management group).

Recommends Action

The Review Committee will recommend the course of action. Should this mean in the case of a union member a discharge, then the very fact that a union representative participated in his decision will go far to mutual acceptance and the prevention of grievance issuance. It is common industrial practice and generally accepted that a probationary employee is usually discharged on his first alcoholic offense. Even in such cases the services of medical and plant counselor should be made available to the dischargee.

Counselor's Responsibility

This plan so far, of course, is applicable only to the employee in the first category mentioned, i.e., the employee who ordinarily would be subject to disciplinary punishment. It is also realized that this plan needs to be tailored to the requirement of each individual plant, yet the presented outline establishes a basic pattern to which can be added or from which can be deleted as needed.

Now how about the employee in the second category who is not yet subject to plant discipline. Certainly he cannot be instructed to go on "Alcohol Procedure". He becomes the

responsibility of the counselor, who in a tactful way will endeavor to advise.

What manner of person is this industrial counselor?

The *successful* counselor can be male or female. Many women are doing an excellent job. The *successful* counselor must be understandingly sympathetic with the problem drinker, yet firm in his request for complete cooperation. The *successful* counselor must have a deep and abiding faith in Almighty God, secure in the knowledge that, when the strength and wisdom of man faileth, there is an inexhaustable supply laid up above, yielded to us through the power of prayer.

The *successful* counselor will be found ready to go to the aid of a distressed and tormented alcoholic at a moment's notice, day or night, work day or holiday—for this is a "round-the-clock" job.

The *successful* counselor is the pivot around which the entire Alcohol Procedure turns. His devotion to the exacting duties and responsibilities of his assignments may well make a man's life and a family's future.

What Are Results?

Does the plan work?

Alcohol literature is loaded with statistics and while I am statistically minded and respectfully bow to our plant statistician, I do not choose to use statistics when I am discussing people; for people are human beings, and human beings differ so much from each other that I have never been able to classify them statistically.

The industrial problem drinker is a person. He is real; I work with him and his problems becomes my problems.

I'd like you to meet John K. Three years ago his superintendent gave him his final warning. The man had two strikes on him—fifteen years of steady d r i n k i n g—completely discouraged. Today he holds a responsible supervisory position. He has had one slip in these three years and none in the past two years. That man was ready for the scrap heap. Today he has his sobriety and the respect of his men. The plan works!

There's Felix X—foreign born, twenty-two years of compulsive drinking, the last few years a pint of whiskey daily. He was referred two years ago and today he is sober with no slips. Oddly enough, he is learning the multiplication tables in English and takes great pride in this new accomplishment. Felix X is a new man. The plan works!

The Plan Works

There's Peter Y—five years of concentrated alcoholism—left his wife and his job when faced with another increase in his family. Repentantly returning, he was reinstated on his job and put on procedure. Seven months of sobriety have followed. The plan works!

There's Jerry Z—an alcoholic from way back, mentally affected and not expected to remain dry, yet for more than two years this man, whose previous attendance record was atrocious, hasn't lost one hour of work because of drinking. Even here, the plan works!

It works because industry has found and received the necessary wholehearted support from "out-plant" groups.

Sources of Help

The Yale Center of Alcohol Studies with its tremendous informative resources and the Connecticut Commission on Alcoholism with its dedicated personnel, its Blue Hill Hospital at Hartford and its clinics located

throughout the State have been a major source of help. Alcoholics Anonymous with its keen understanding and sound grasp of the problem has given industry its full support. Public and private agencies shared their facilities and experience with us. And the professions, including clergy, legal, penal, banking, nursing, medical, teaching, to name but a few, have shown a most sympathetic understanding and willingness to assist in the rehabilitation of the problem drinker.

No, there is no such thing as a fool-proof plan. We too have our failures, but many of these are the "chronic" alcoholics, many of the "hold overs" from war days—men who are not able to stand up under the constant pounding and pressure of today's production requirements—men who crack under the stress and strain of today's industrial needs.

Yes, industry indeed has taken a "second" look at its age old problem and industry now has both eyes wide open, its sleeves rolled up and working. The alcoholic employee knows that counsel and guidance and help are his for the asking. He knows, because he has seen with his own eyes the evidence in the experience of other employees like him. Yes, the plan works!

Will it work for everyone?

That depends on the individual. There are some people who in their own way have found personal happiness in alcoholism. They have no desire to change. But I recall with grateful pleasure, the TV lectures on alcoholism by Bishop Fulton J. Sheen, and I would like to close on the high note of his final broadcast when this great good man faced his millions of listeners and in ringing tones declared, "There is no such thing as a hopeless case." That I believe.

MOST people understand love to mean simply love between the sexes. It does mean this, but also much more. On the deepest level, love is an instinctive force present in every person from birth to death. It is a profound urge to preserve and extend life by means of union with another living force, and it expresses itself through an exchange of energy that mutually strengthens and rejuvenates.

Love is born when the child rests in its mother's arms. From this beginning, love grows until it includes the love of family and friends, of school and country, and ultimately of all the world. Love also means love of self. This is an aspect often ignored, yet it is of basic importance —for without healthy self-love, one cannot love anyone else. Love also means love of God, a love that sustains us when human relationships crumble.

Love is all of one piece—from the love of mother and child to the love of sweethearts, husbands and wives, and friends. It is present, too, in the laborer's devotion to his work, in the teacher's solicitude for her pupils, in the physician's dedication to his art. All that heals, cultivates, protects, and inspires—all this is a part of love.

To say that one will perish without love does not mean that everyone without adequate love dies. Many do, for without love the will to live is often impaired to such an extent that a person's resistance is critically lowered and death follows. But most of the time, lack of love makes people depressed, anxious and without zest for life. They remain lonely and unhappy, without friends or work they care for, their life a barren treadmill, stripped of all creative action and joy. From "Love or Perish", by Smiley Blanton, M.D.

A CULTURAL VIEW OF MAN'S DRINKING HABITS

BY EBBE CURTIS HOFF, Ph.D., M.D.

From the primitive to modern man, the use of alcohol has been influenced by religious and social customs.

THERE seems little question that the intoxicating, exhilarating effects of fermented sugars and other carbohydrates were known before the dawn of history. Primitive man doubtless experimented with eating all kinds of fresh and rotting fruit as well as the leaves, bark, roots, flowers and seeds of plants. In the course of all this experimentation he encountered not only ethyl alcohol but also substances with various medicinal properties, including the opiates. So far as I know, the earliest records of the most ancient civilizations contain commentaries on alcoholic beverages, including their proper and improper uses, as well as special restrictions of their use by certain persons, and at certain times and places. From the beginning of civilization it appears that alcoholic beverages were thought of as potent substances over which society pro-

Condensed from an address delivered at the Fourth Annual North Conway Institute, North Conway, New Hampshire, June 1958. Reprinted by permission.

perly exercised control. This is not to say that there are examples of cultures that were free from problems of the pathological use of alcohol, since drunkenness and alcoholism, as we understand these terms today, seem to have presented serious difficulties from the beginning.

Most cultures established deeply ingrained attitudes towards the consumption of alcoholic beverages with differing degrees of sanction against those who deviated far from these attitudes. There are a few cultures where alcohol was not found. This was the case in the pre-Columbian Indians of North America in most of the area now constituting the United States.

With few exceptions such as that just referred to, the preparation and drinking of fermented liquors is one of the commonest practices of man in all civilizations. Certainly in modern times the use of alcoholic beverages is well established universally, in spite of some religious and cultural prohibitions or restrictions. The problems associated with alcohol have taken on new dimensions since the discovery in the middle ages of distillation of fermented mixtures, and the same may be said for the problems of the use, for example, of opium. In both cases modern man now has a concentrated drug constituting an essential chemical compound in its relatively pure form.

Modern use of alcoholic beverages rests upon motivations and practices which are a part of the cultural stream that has flowed without interruption from the beginning of civilization. It may help us in our present thinking about alcohol education to speculate upon some of these attitudes and cultural motivations of the past.

It seems that primitive man regarded alcoholic beverages as a miraculous means of communion and communication with the supernatural. Alcoholic intoxication afforded unique freedom from orientation to the ordinary world with its cares and problems and lifted man to a state of exaltation in which he felt powerful and gifted with transcendent thoughts; as he continued to drink he finally fell into a deep sleep. There seemed no reason not to experience the whole series of effects of alcohol, from the first exhilaration to the final coma.

Religious Rites

Magical and religious rites of primitive people usually included at one stage or another the use of fermented beverages, and this custom comes down to modern times. One of the reasons why drinking by many modern American Indians is a problem is that their use of alcohol follows the old pattern of drinking to deep intoxication and coma. For example, the Navajo Indians of the Southwest drink sweet wine as a part of their Saturday afternoon shopping trips to border towns like Gallup, New Mexico. The father, mother and the children all come to town from the reservation in their half-trucks. They park in the super-market parking space, buy their groceries, talk with their neighbors who are also in town, and then go to the saloons. within easy walking distance and proceed to drink deeply and rapidly to the point of profound inebriety. On a busy Saturday afternoon, even before sundown, scores, or sometimes hundreds of Indians may be seen in the dried-up creek that runs through the town of Gallup, lying in an alcoholic stupor. That night the town jail is full of Indians—both men and women.

This kind of use of alcohol may have been relatively unharmful in

primitive tribes where modern civilization did not complicate living, and where the affairs of the tribe could wait until recovery from the orgy. In modern Gallup, New Mexico, however, we see two dissimilar cultures confronting one another, the modern, mechanized industrialized "Anglo" culture impinging upon what remains of the primitive nomadic, sheep-growing Navajo culture. The problem of drinking among the Navajos is the problem of a people who drink in a primitive fashion, but who have lost most of the strength and directional vitality of their own religious and ethnic heritage that might serve to set limits and bounds to their drinking.

The use of a drug as a breakthrough to the supernatural is by no means limited to alcohol. Opium and other psychopharmacological drugs have been so used in the Orient and are still so used in many parts of the world. A modern example is the religious use of the drug Peyote by Southwestern American Indians. This drug produces transcendent, exalted states, culminating in a sleep and in the modern Peyote religion its use is associated with a rather elaborately developed religious ritual. An essential statement of the Peyote religion is that whereas the white man communes with God through his science, educated reason, and other characteristics of presumed superiority, the poor Indian approaches God through Chief Peyote.

Gladdening the Heart

One of the properties of alcohol common to certain other drugs is that it imparts, temporarily at least, a sense of wonderful lucidity and detachment of the mind and the consciousness. There is a joyousness and freedom from care which is quite unique. Many ancient writings refer to wine gladdening the heart of man. It has been said, in fact, that the effect is to take away the inhibitions and veneer of civilization and reveal the real or true self. It would appear that this effect of alcohol stems from its peculiar selective action upon the central nervous system. For some reason, not entirely clear yet, the phylogenetically newer, upper parts of the nervous system, namely, certain portions of the cerebral cortex, are more sensitive to the anesthetizing effects of alcohol than are the lower parts. Therefore, the earliest effects of alcohol are predominantly psychological and include release from care and inhibitions as well as social restraints. As the blood alcohol level rises, the sensory and motor parts of the brain begin to be depressed and finally, with higher blood levels still, the person is not only unable to walk, see or hear properly, but also falls into a coma and may even die from respiratory failure as the breathing center in the lower part of the brain stem is rendered inactive. The effects of alcohol thus may be described in serial stages, beginning with minor relaxation and release of tension, progressing to moderate or serious incoordination of movement, and disturbances of sensation, and finally ending with arrest of breathing.

That alcoholic beverages "gladden the heart" is a matter of universal experience, and yet people seem to differ in the quality and amount of gladness which alcohol brings them. Some find that drinking more than a small amount makes them feel stupid, sleepy, and disinterested or even anxious and uncomfortable. Obviously, the effects of alcohol in small or large amounts depend to an important extent upon the psychological and other characteristics of the person himself. There are quite

ABOUT THE AUTHOR

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Dr. Hoff is a graduate of the University of Washington. He then attended the University of Oxford, England, where he earned the M.A. and Ph.D. (in neurophysiology) and the degree of Doctor of Medicine.

His wide-ranging career has included research and teaching, wartime hospital service in London, a stint as U. S. Navy Flight Surgeon and a tour of duty as Naval Attache in the U. S. diplomatic service.

wide individual differences.

Of all the cultural patterns associated with alcoholic beverages, social drinking is without question the most universal. The term, social drinking requires careful thought as to its definition. It should be remembered that drinking by people together in groups does not necessarily constitute social drinking. For use of alcohol to be properly described as social, it is necessary that the drinking facilitate social interrelations within the group. The extent to which the drinking hampers or destroys social intercourse measures the deterioration of the social character of the drinking. For example, at a large cocktail party the beginning of the party may be an occasion of good social interrelationships but as drinking continues, and the noise level rises, it is frequently the case that very few people may be having a truly social experience, since communication breaks down. Social Drinking, therefore, must be defined as only that use of alcohol beverages which promotes relationships between two or more people. The term *social drinking* should be applied only to those drinking occasions in which the social relationships are the primary purpose, and the drinking secondary and supportive. A party in which the main purpose is to drink, lies outside the definition of *social drinking,* and falls under some other definition such as *psychological drinking.*

A Symbol of Life

In many cultures these are symbolic links between wine and blood. In some humoral concepts of human function, the blood is considered to be the source of life. This is doubtlessly based on the observation that serious hemorrhage from a wound can be fatal. As the blood is the life of the animal, so the wine is the life of the grape. Thus, we find a thread of symbolism running through the history of culture in which wine is related to strength and life. Among French laborers the use of wine is traditionally held to impart strength necessary for work, especially for heavy labor. The practice of giving out rations of "grog" in the Royal Navy was presumably initiated as a way of helping the seaman endure the hardships and rigors of life aboard ship.

In our American culture it seems that the ability to drink successfully is sometimes seen as a badge of virility. Christopher Sower has re-

ported that among the teen-age young people whom he has studied, the use of alcohol is a sign of maturity, adulthood, independence, and manliness. Many alcoholic patients seen in the Division of Alcohol Studies and Rehabilitation in the Commonwealth of Virginia, express in one way or another a chagrin over a "weakness" which prevents them handling their drinking as they feel they used to, or should. Often for many years, an alcoholic will attempt to find a satisfactory drinking pattern, driven by a need to prove that he can "take it".

Attitudes Toward Drunkenness

While most ancient writings about alcohol contain the praises of wine in some forms of its use, there is also attention to the dangers of drunkenness. The Hebrew literature offers excellent examples. The difficulty arises in the definition of drunkenness. As in ancient times, so in modern, there are different cultural definitions of drunkenness and different degrees of sanction applied against drunkenness under certain circumstances and occasions. In a personal communication, Jellinek has reported prevalent attitudes toward drunkenness in certain cultural groups in Italy and France. In his Italian groups Jellinek has found that lesser degrees of deviant behavior are called drunkenness than is the case in France. The Italian groups will socially tolerate much less in the way of drunken behavior than the French groups, and there appears to be few occasions in the former groups when sanctions against drunkenness are temporarily suspended. The fact that a young man gets drunk occasionally might, for example, be sufficient reason for an Italian parent to refuse consent to a marriage with his daughter. On the contrary, in the French groups which Jellinek evaluated, weekend drunkenness may be accepted as a natural thing in some people by family, friends and neighbors. There are undoubtedly exceptions to these general conclusions in both the French and the Italians.

In the United States, acceptance of drunkenness varies greatly in different groups. Certain characteristic attitudes may be generally held by certain religious groups, and there may be differences according to town and country people, or those working in different occupations. I believe that well conducted evaluation studies, like those of Jellinek, will reveal that within a group such as an individual church congregation, there will be quite a wide variation in attitudes toward drunkenness, as well as the definition of what constitutes drunkenness. In certain segments of American society a guest will be thought of as having drunk "too much" if he becomes noisy and overtalkative and may thereby bring disfavor upon himself. Others will regard him with friendly tolerance so long as he seems to be enjoying himself and is not embarrassing the other guests. Still others would not take offense unless the guest becomes aggressive, told questionable stories or made advances to the opposite sex. In most American suburban cultures, a woman's drinking behavior is subject to more stringent, critical standards. This is not universally true however.

There is no unequivocal definition of alcoholism. In the latter half of the nineteenth century, and the early part of the present century, one spoke of inebriety, or chronic drunkenness. Those who became drunk frequently, or showed some pattern of loss of control of their capacity to drink or not to drink, were spoken of as having acquired the "drinking

habit". It is quite clear now that alcoholism, however defined, transcends the characteristics of a habit, and may appropriately be thought of as an addiction, or compulsion. Although terms like "drunkard", "inebriate", and "dypsomaniac" are falling out of use, the term "alcoholic" is used now in a variety of meanings. The homeless, transient "skid-row" man may be spoken of as alcoholic since he depends greatly on alcohol, and yet the primary disorder of such persons is probably their lack of status in an acceptable, stable society. The alcoholic as he is seen in A.A., or in the rehabilitation clinics, is a person who has to a greater or less degree, lost control of his use of alcohol, and does not really know when he will be drunk again. His pattern may vary, and the underlying pathological processes responsible for his behavior are probably also variable. A characteristic of the alcoholic which has definite meaning is that his drinking is associated with deterioration of his health, interpersonal relations, and way of life generally. Some definitions of alcoholism include the feature that the alcoholic's drinking deviates in certain particulars from the accepted standards of the culture in which he lives. This latter feature makes it difficult to agree upon a universal definition.

Today we look with hope towards research in physiology, biochemistry and pharmacology. We still have faith in the research efforts of the psychologist and psychiatrist. We listen respectfully to ideas from sociology and anthropology, and we still accord a listening ear to the educators and preventive medical men. We are in the phase now of expecting results from interdisciplinary teams working together and I think it is realistic, also, to expect that community self-evaluation of its own drinking patterns and pathologies can lead towards a more effective control of alcohol use.

ALCOHOLIC'S GREATEST NEEDS

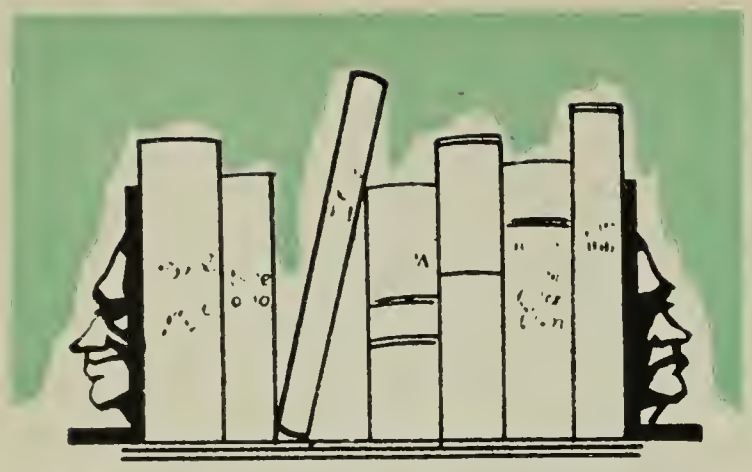
(Continued from page 15)

does not use the ups and downs of the alcoholics in therapy as a criteria for the measurement of his success or failure as a therapist; otherwise he will become despondent and ready to quit before he has really gotten started. It cannot be repeated too often, *the course of therapy is a rough and stormy one and one must be prepared to weather many, many storms before any degree of smooth sailing becomes possible.*

And last, but not least, as in working with any difficult problem, *one must set realistic goals—goals that are patient-oriented—that is, related to the patient's emotional resources, potentialities and limitations, and are not related to some idealistic goal that we may project for our patients to reach.* Such an idealistic goal is too often an idealized self-image, having little to do with the very real person with problems that we are trying to help.

To succeed in working with the alcoholic one must be prepared to fail time and time again in order to reach success.

The Federal Bureau of Investigation reports for 1957, that in 198 cities over 25,000 population 578,336 persons were found guilty of drunkenness, disorderly conduct, and vagrancy. Some 42,642 were found guilty of driving while intoxicated and 16,227 were guilty of violation of the liquor laws.



Books of Interest

ALCOHOLISM

By Arnold Z. Pfeffer, M.D.
Grume and Stratton
New York
98 pp.

ALTHOUGH this little book is intended to be one of a series on Industrial Medicine it is written in a concise and yet encompassing style which will appeal to readers other than those specializing in industrial medical practice. The author is Director of the Consultation Clinic for Alcoholism at the University Hospital of New York University-Bellevue Medical Center, sponsored since 1952 by the Consolidated Edison Company of New York. This Clinic devotes attention exclusively to the alcoholic patient in industry and evolves from the modern policies of the Consolidated Edison Company toward alcoholism, which have been maintained since 1947. In this Company there is a known annual incidence of 1½ to 2 new cases of alcoholism per thousand employees per year. In industry in general there is probably an overall total of 2% of alcoholics, hidden or known. The alcoholic in industry loses working time, is more liable to other illnesses and accidents, and fails satisfactorily to fill his place on the team. As a result he often has been dismissed from his job in spite of the long years of training which led to his filling that position. Industry cannot afford such a waste and any program of the sort described by Dr. Pfeffer is bound to pay useful returns whether looked at financially, industrially, medically, psychologically, or from the point of view of the worker and his family.

There is an excellent chapter on the etiology of alcoholism with emphasis being placed on the known psychological factors rather than on more theoretical areas such as constitution and diet. There follows a brief but comprehensive discussion of the medical management of the alcoholic and some useful references are included. The chapters on the psychology of alcoholism are excellently done in a small space and Dr. Pfeffer's views on the treatment are presented with moderation and flexibility—exactly the same kind of approach he must bring to his alcoholic patients.

Essentially the first sixty pages of this book constitute an excellent refresher course on alcoholism for anyone, but particularly for physicians, who want to be brought up to date as painlessly as possible. The rest of the book describes the Consolidated Edison Company Procedure on Alcoholism, and the University Clinic for Alcoholism.

Undoubtedly the things described by Dr. Pfeffer can serve as a model plan for any other industry and indeed he mentions possible solutions for setting up similar programs in small companies. This book should be in the possession of all who specialize in industrial medicine and I would hope that it would reach the hands of industrial management also.

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ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

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For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
615 Wills Forest Rd.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: AL 3-8343
Monday through Friday

Alcoholism Clinic of the
Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: ED 3-5441 & ED 3-5442
Monday through Friday

Forsyth County Program
On Alcoholism
7th & Woodland, Streets
WINSTON-SALEM , N. C.
Phone: PArk 3-2471, Ext. 29
Monday through Friday

Cumberland County
Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
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The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

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MARCH - APRIL, 1959

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

REATMENT

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N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

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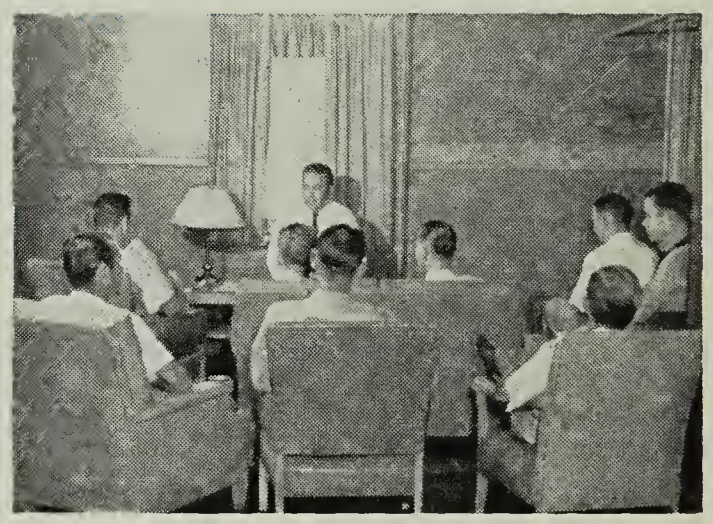
2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.



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ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Executive Director

ROBERTA LYTLE, R.N., M.S.Sc.
Psychiatric Social Work Consultant

GEORGE ADAMS
Educational Director

INVENTORY

VOLUME VIII NUMBER 6

MARCH-APRIL, 1959

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices Old Health Bldg., Raleigh, North Carolina.

CLAIRE CHENEY
Editor

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Circulation Manager

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ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

A Senator Writes

Thank you so much for your two copies of your educational journal on alcohol and alcoholism. I am most interested in your program and you are to be commended for the excellent job you are doing. Please do not hesitate to call on me whenever I can be of service.

The Honorable John R. Jordon
North Carolina State Senate
Raleigh

An Old Friend Writes

It has been my good fortune to read of the fine work your state of North Carolina is doing in the field of alcoholic rehabilitation. As a minister of the Southern Baptist Convention, I am facing this grave problem of alcoholism in the community of which I am now serving. While I was at Southeastern Seminary last year I visited your offices in Raleigh and received much helpful literature on this subject. I am requesting that you put my name on your mailing list.

Harold T. Rochester
Lowndesville, S. C.

Thanks Program

Thank you for your prompt reply to my recent letter and for your generous offer to supply us with 200 copies of your November-December issue of INVENTORY. I can assure you that they will be put to good use and I am most grateful for your splendid cooperation.

Mrs. Louise K. Kent
Educational Director
Detroit Committee on Alcoholism

Wants TV Information

Several months ago I recall having seen in INVENTORY a write-up of your use of slides in advertising the ARP on TV. This information is needed for study by our Education Advisory Committee. If you have a spare copy of the issue referred to, I would appreciate your sending it. I would also consider it a favor if you would put my name on your mailing list.

Frank B. Campbell
Education Director
Texas Commission on Alcoholism

An Editor Writes

Many thanks for continually sending INVENTORY my way. I enjoy it very much and find it full of good, sound advice to the alcoholic. Being an AA "loner", I find such material to be ever useful. I have taken the liberty of using some of your material for the "Loner's Review", believing that many more people should see it. I hope this meets with your approval.

Editor
"The Loner's Review"
Hamburg, N. Y.

News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

WASHINGTON: A new pamphlet, published by the U. S. Public Health Service entitled "What You Should Know About Alcoholism" is now available at 15 cents a copy from the Superintendent of Documents, Government Printing Office, Washington 25, D. C. The number of the publication is PHS Publication 93.

NEW YORK: The American Society of Group Psychotherapy and Psychodrama will hold its annual conference in New York City, April 24 and 25. Miss Roberta Lytle, Psychiatric Social Work Consultant with the ARP, will discuss a joint paper given by Dr. Ruth Fox, noted psychiatrist and author, and Hannah Weiner, well-known psychodramatist.

WASHINGTON: Members of Region III of the National Institute of Mental Health met March 16 and 17, in Washington for an exchange of ideas for the betterment of alcoholism programs. NIMH officials participated in the meeting. Attending from the ARP were Dr. Norbert Kelly, Executive Director, George Adams, Educational Director, and Miss Roberta Lytle, Psychiatric Social Work Consultant.

COLUMBUS, OHIO: The Legislative Committee of the Columbus Health Department is now working on a bill which would create a division on alcoholism in the Ohio Health Department. The movement was started under the auspices of the Ohio Citizens' Council and representatives of alcoholism agencies throughout the state.

ALABAMA: 1958 graduate of the Yale Summer School of Alcohol Studies and Educational Director for the Alabama Commission on Alcoholism, John Sanders is now editing a YSSAS Newsletter for all Alabama graduates of Yale. The purpose of the Newsletter is to keep up-to-date on the whereabouts of the Alabama alumni plus a media for learning about the latest significant events in the field of alcohol education, treatment and research. Address of the Alumni Association is 704 Washington Avenue, Montgomery.

GREENSBORO: For the second straight year, the Greensboro Council on Alcoholism is sponsoring an Alcohol Education Week. Highlight of this year's conference, which will take place May 4-7, in Greensboro, is a conference on the prison alcoholic. The ARP will act as advisor to the GCA in preparing and presenting an effective program on alcoholism and the alcoholic for the many prison officials who are expected to attend. Featured speaker will be Roberts J. Wright of Valhalla, New York, Warden of Westchester County Penitentiary and President of the American Correctional Association.

ASHEVILLE: The Educational Division of the ABC Board in Asheville is holding a Ministers' Conference on Alcoholism for ministers of all denominations in the Western North Carolina area on April 7. The ARP will take part in the program.

NORTH CAROLINA: The ARP had on display two educational exhibits during the month of March—one at the Charlotte Occupational Health Conference held on March 12, and the other at the meeting of the N. C. Education Association, March 18-20, at Asheville.

UTAH: The National Council on Alcoholism held its annual meeting and institutes in Salt Lake City, March 18, 19, and 20. The theme for this year's conferences was "Counterattack on Alcoholism." Participating in the conferences were such well known experts on alcoholism as Mrs. Marty Mann, Dr. Ruth Fox, Dr. Joan Jackson, and William J. Plunkert.

MARYLAND: The Mid-Atlantic Region Social Work Workshop was held at Buckeystown, March 5 and 6. The Workshop, which attracted social workers from Pennsylvania down through North Carolina, was held at the Claggett Diocesan Conference Center. Miss Roberta Lytle of the ARP staff attended.

NORTH CAROLINA: The 1959 Nurses' Institute on Alcoholism will be held at Wilmington, April 10. This is the fourth annual Institute for nurses sponsored jointly by the three state nurses' associations and the ARP. Public health, private, and institutional nurses from throughout North Carolina are expected to attend. Details of the Institute can be found on page 9 of this magazine.

NEW YORK: The National Council on Alcoholism has announced the untimely death of Denis C. McGenty, Director of Professional Education of the National Council. Mr. McGenty died suddenly of a heart attack on February 28 in New York City. Mr. McGenty was well known as a friend to all alcoholics and as a leader in the field of alcoholism education. His loss will be felt greatly, not only by the NCA, but by his many friends and co-workers throughout the country.

FLORIDA: From the Florida Alcoholic Rehabilitation Program comes the news that the National Tuberculosis Association in conjunction with the National Council on Alcoholism has published a leaflet on alcoholism entitled, "A Disease—Not a Disgrace", plus an accompanying poster. Copies of the pamphlet and poster may be had by writing your local TB chapter. They will not be distributed on a national level.

NORTH CAROLINA: For the 5th consecutive year, the ARP will sponsor and lead two summer sessions on facts about alcohol for teachers and prospective teachers throughout the State. This year, the summer school session will be taught at East Carolina College in Greenville, June 9-19, and North Carolina College in Durham, also June 9-19. The course of study will be designed for better understanding of the sociological, psychological and physiological problems which arise from the use and mis-use of alcoholic beverages. For details of the summer sessions, write to Director of Admissions at either one of the two colleges.

VOL. VIII, NO. 6 **INVENTORY** MARCH-APRIL, 1959

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

AN "INSIDE LOOK" AT THE ALCOHOLIC

by

Denis C. McGenty

YOU can't understand alcoholics by studying them from the outside in. If you take this approach you see only an irrational kind of behavior. What they do just doesn't make sense to you. To understand alcoholics, you must try to get inside their set of values, learn what motivates them to behave as they do, find out what makes them tick. You must study them from the inside out. Their behavior may still be irrational according to your set of values, but at least from theirs, you will see that their actions make sense.

I call alcoholics "outs". This name

seems to be singularly suited, almost poetically appropriate, for these unfortunates. On their way down in the course of their progressive disease, they are increasingly passed out, conked out, out on their feet, out like a light, or just plain knocked out cold—literally out of this world! Their drinking habits and patterns are "outside" the accepted social norms. They are out of a job. Parents tell them to get out and stay out. Spouses order them out of the house. Bartenders throw them out. And at least until recently, judges were disposed to give them forty-eight hours to get out of town. They end up, *down and out.* The "outs" indeed.

How Do They Get That Way?

Certainly being an alcoholic is not a desirable condition to be in—viewed from the outside. Why, then, are there alcoholics? Are they born with a tendency to drink? Are there certain types more prone to liquor? How do they get that way? Do other members of the family, perhaps unknowingly, actually help them on the treadmill? These are questions on which a considerable amount of light has been shed since experts have taken to viewing alcoholics from the inside out. We know that alcoholism is a disease and the alcoholic is a seriously sick person. It also is known that people are not born alcoholics, or with a predisposition toward alcoholism. Extensive research has not been able to prove that persons of one type are more likely to become alcoholics, than persons of another type. Not all alcoholics are on skid row—in fact less than 15% are. And of these, only 25% are alcoholics . . . the rest are social misfits, professional beggars, psychopaths, and the like. So actually 88% to 92% of actual alcoholics are not flop-house characters. They live next door to you, work at the next desk, or factory bench, or possibly they are even closer to home than that. They may be a member of your family.

Four out of five alcoholics are employed or employable. At least one out of five is a woman. They are in all walks of life, all economic, educational, and social strata, regardless of race, creed or color. In the U. S., which ranks first in the world, there are nearly 5,000,000 persons with the disease of alcoholism. Their illness ranks third as a national health problem, following only heart disease and cancer. But the outlook for an alcoholic can be far more hopeful than for the person having cancer. The alcoholic can be helped. His illness can be arrested. He can be restored to a happy and constructive role in family and community. For an understanding of what an alcoholic is, it is necessary to distinguish between him and simply a heavy drinker. A heavy drinker is one who can stop or cut down when he has a convincing reason. The alcoholic cannot stop even in the face of literally fatal reasons.

Many Types

We used to think that all alcoholics were alike—weak characters who couldn't, or wouldn't take it. Today we know there are many kinds of alcoholics and that almost any therapy, provided it includes love, will help some of them. It always was thought that the alcoholic deliberately, with unfettered free will, chose to be what he is. But recently careful research has revealed two important points:

1. That early in life, especially during pre-adolescence, oftentimes parent-child relationships created the seed-bed for alcoholism:

2. That recurrent family relationships tend to trigger and retrigger

the need to drink compulsively and you will find four characteristics common to alcoholics:

a. Egocentricity (a person extremely self-centered)
b. Inability to face external pressures (in sociology, called low tolerance for tension)
c. Over-dependence and
d. paradoxically, a sense of omnipotence

It is my opinion that to the alcoholic (as he views it from the inside), all four of these traits are compensation mechanisms for a deep, underlying sense of inadequacy.

Let us trace what happens in an alcoholic and view life as he does from the inside.

A Look Inside

First of all, in most cases, he has had some abnormal parent-child relationship. This marks him with a deep, persistent sense of being rejected, so that ever after he is painfully insecure. This insecurity affects his behavior. He becomes egocentric, with everything revolving about himself. To protect his frail ego against what he considers outside threats, he develops a belligerent exterior as a defense mechanism. To illustrate this attitude in another situation, suppose a person with a sore toe is in a crowd. His whole attention is focused on protecting the sore toe from being stepped on. To do this he may elbow and push others rudely, things he probably would not do if it were not for the sore toe. The insecurity developed early in life makes him dependent on others repeatedly as he confronts the realities of life. This increases his initial sense of worthlessness. He feels rejected. He feels he should be rejected. A "selective" sensitivity seeks out rejection where it occurs, anticipates and interprets rejection where none is offered. It makes him distrust, even blinds him to, evidence of acceptance.

Like an infant, he tries desperately time and again to walk alone and erect. But his lack of self-confidence, his low level of self-regard, and his painful sense of inadequacy trip him up repeatedly into the dependence he has loudly renounced. His one hope of escape is a never-never land of omnipotence, where insecurity will be no more, and where no one will reject. There will be, at long last, acceptance. There will be love. The alcoholic does not know this is happening to him. He knows only the pain—constant psychic pain—and desperate loneliness. One day, by chance, he discovers alcohol, which in our modern culture and society is generally accepted. It is a magic elixir, not of intoxication, but to him one of elation. Instantly tension is relaxed. Gone suddenly is nagging insecurity. Elation brings an immediate sense of grandiosity, of omnipotence. No more dependence. The mouse becomes a giant, a demi-god striding the universe. It is my firm conviction that, to the alcoholic, alcoholism is the solution to his problem before it is the cause. From the inside out, his drinking makes sense. It is a defense mechanism.

A Rejecting God

Where he knows God at all, the alcoholic selects only certain attributes of God on which he dwells to the exclusion of their opposites. Based on his parent-conditioned insecurity, low self-regard and intense guilt feelings, he sees God as all-powerful, all-knowing, all-just. Since His justice is supreme, therefore He will punish evil, reject the unworthy, and therefore reject him. This unconscious, neurotic selectivity completely excludes an aware-

ness of the opposite attributes, of God as all-loving, all merciful, all-forgiving, imminently helpful. It is because a balanced understanding of God is restored through its program of personal conversion or "spiritual awakening" that Alcoholics Anonymous is so effective in the recovery of alcoholics! One authority, Dr. H. M. Tiebout, believes the force of religion in an atmosphere of hope and encouragement, in the AA program, produces a profound change in the typically egocentric, alcoholic personality, dominated by defiant individuality and drives for omnipotence The negative characteristics of aggression, hostility and isolation are replaced by peace and calm, and a lessening of inner tension.

The types of women who marry actual or potential alcoholics to answer a need of their own can be identified by their names. (1) Controlling Catherine (2) Suffering Susan (3) Punitive Polly and (4) Wavering Winifred. Husbands of alcoholics also fall into four classifications. (1) Coddling Charlie, the long suffering martyr who mothers and spoils his child-wife (2) Bewildered Bennie, who leaves furiously but comes running back (3) Unforgiving Freddie, unrelenting and self-righteous; and (4) Sadistic Sam, the punishing, sadistic variety. All of these may control, suffer, punish, waver and coddle loudly while the neighbors sympathize. But they want things as they are to satisfy an unconscious need of their own. In fact, when the alcoholic husband becomes abstinent, his wife, no longer able to satisfy her need and unable to adjust, reacts with severe depression, at times requiring that she be institutionalized. So while the wife may not be responsible for her husband's illness, she may be one of the reasons for this continued drinking.

The attitude of the family is extremely important in the rehabilitation of the alcoholic. *The family should provide a therapeutic setting for recovery.* I find that when we request the family member to come to our Alcoholism Information Center for a visit, usually the prompt and indignant response is, "What do you want to see me for? There's nothing wrong with me. He's the one!" But so often it isn't only "him". If I were asked to name the single family attitude most obstructive to recovery, I would say it is the tendency to verbalize an acceptance and understanding of alcoholism as a disease while emotionally rejecting the alcoholic as "weak-willed" and deliberate in his drinking. When family members do come in, they recite a long-accumulated litany of grievances. Then they listen patiently as the counselor explains the nature of the disease, its compulsive character, the list of symptoms, the need in the family for courage, patience, sympathy, understanding, but above all, love.

"Yes, of course, I know it's a disease," they reply. "I know he's sick. But don't you think, if he really loved me, he'd quit?"

This proves the person doesn't really understand. He wouldn't say to a cardiac, "Yes, John, I know you have heart trouble. I know you must have bedrest for six weeks. But, we can't afford for you to have heart trouble. Why don't you just stop it? If you really loved me, you would!" To help an alcoholic, you must understand him. To understand him, you must know him from the inside out. Only with an inside view will you really get to understand the alcoholic's make-up and thus, with love and patience, be able to help him. (*Until his recent death, Mr. McGenty was Director of Professional Education of the National Council on Alcoholism.*)

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April 10, Fellowship Hall, Grace Methodist Church, Wilmington, N. C.

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SPEAKERS

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JOHN A. EWING, M.D., D.P.M., Assistant Professor of Psychiatry, University of North Carolina School of Medicine

ROBERTA E. LYTLE, M.S.Sc., Psychiatric Social Work Consultant, NCARP

NORBERT L. KELLY, Ph.D., Executive Director, NCARP

FAYE SPRING, R.N., M.S., Assistant Professor of Nursing, Duke University School of Medicine

A nurse experienced in caring for alcoholics tells why she thinks

Alcoholics Are Sick People

by

Theresa M. Rohan, R.N.

Reprinted from "Georgia Nursing"

ALTHOUGH there may be some question as to whether alcoholism should be classed as an ailment, a sickness, a disease or (as Dr. L. A. Osborn defined it in the Journal of A.M.A.) a "dis-ease", it is pretty generally agreed that the active, compulsive alcoholic is a very sick person and deserves the medical care he is beginning to receive in the alcoholic wards or clinics of more and more hospitals.

It is necessary to subscribe to the belief that alcoholism—or compulsive drinking is an illness in order to justify my work in the alcoholic ward of the Knickerbocker Hospital in New York. However, the authority of the hospital staff and the medical profession was not necessary to convince me that alcoholics are sick people. My own experience with them, over a period of five years, would have given me that conviction, even if I were the only person in the hospital who held it.

Nursing the alcoholic requires no specialized knowledge and no departure from normal nursing routine, with the possible exception of the first step which is described as "sobering up the man." Then the only requirement is a little patience and an elementary understanding of the easily understood reactions of the alcoholic who may be definitely "active" when he arrives for treatment.

When an alcoholic patient is admitted to Knickerbocker he is examined by an interne and the following day by one of the rotating medical staff. From the nurse's viewpoint the first three or four hours of the first day are the busiest because all patients admitted at Knickerbocker are ambulatory, and a good percentage are still "under the influence" on arrival. It usually requires the first three or four hours to get them adjusted and for the treatment to begin to take effect and a patient may require maximum attention during this period. In actual practice this is neither as big nor as busy a responsibility as it may sound. Experience soon teaches that if the alcoholic is allowed to walk and/or talk during the "waiting" period, he causes little or no trouble and requires little more than normal attention. This is invariably the case if the nurse makes it clear at the start that she regards him as a sick person and expects him to act like one. Since most alcoholics have been told that they are, and have come to regard themselves as, "drunks" or "drunken bums", this sympathetic attitude comes as such a wonderfully pleasant surprise that it invariably brings out the very best in the patient. In this connection, it is interesting to note that during my five years in the alcoholic ward at Knickerbocker, there has never been the slightest danger of physical violence from any patient, for the very good reason that there has never been any attempt to use physical restraint in handling a patient. Following this first period comes sleep induced by treatment, exhaustion, the alcoholic's screaming nerves and (believe it or not) his overactive conscience. It is important to ask the patient when he has had his last drink and if he has had any sleep. Sleep is extremely important at this stage of the treatment since it helps break the tension under which the alcoholic has been suffering.

The Acute Stage of Hangover

Following an average period of two to three hours' sleep, the obvious effects of the alcohol consumed wear off and usually are replaced by tremors, which the alcoholic identifies as "the shakes" plus diaphoresis and vomiting, which he calls the

"dry heaves". Proper treatment usually pulls the alcoholic through this acute stage of his hangover.

The second day's treatment for the alcoholic is comparatively simple from the standpoint of nursing routine, but the nurse who wants to see her patient make the quickest and most complete recovery possible can help and hurry things along enormously at this crucial point by a cheerful attitude, entirely free from the morning-after recrimination he is expecting. Almost invariably, the second day alcoholic is depressed, remorseful, meek and apologetic, and will gratefully seize on the assurance that the past is over and today's recovery is the only important business at hand.

Introduced to "Duffy's Tavern"

Everything is a struggle for the alcoholic his second day, especially eating, sleeping and meeting people. But he should be encouraged to do all three, especially the latter. Although still not allowed to stay in a single or double room, the alcoholic is introduced to the community room known as "Duffy's Tavern" as soon as he is able to take stock of his surroundings and wonder what happens next. Nothing is so reassuring to the shaking and anxiety-ridden alcoholic as to be greeted with the sympathetic and knowing smiles of the three, four and five-day "old-timers" in "Duffy's Tavern", who have passed through the crisis and are now well on their way to recovery. This sympathetic group therapy is so powerful that I have seen a new patient who couldn't hold his head in his hands a few moments before, ask for a razor so he can shave and begin to look a little more presentable.

Action as well as talk is desirable during this three-day period, and all patients are given little jobs to do to help ease the physical tension they may develop. The biggest job, of course, is helping the nurse to take care of the incoming alcoholics by talking to them during their first period of talkativeness and sitting with them during the following periods of alcoholic wakefulness. It is doubtful any nurse in any other type ward has so many willing and understanding helpers.

From the above you will see that this five-day description of the average alcoholic's progress is more a picture of the alcoholic than a review of the nursing routine in an alcoholic ward. The actual nursing duties for this type of patient are almost identical to the routine for any ambulatory patient who suffers through a mild crisis during his first day or two of hospitalization and then begins a three-day period of gradual recovery.

A True Picture

A true picture of the average alcoholic is more important to the nurse who may be called upon to handle one, or who may be considering entering this field, than a detailed report on the nursing practices with which she is already familiar. It is helpful to know, for example, that by the time an alcoholic decides to go to a hospital for help, he is a pretty confused and beaten-down individual who badly needs understanding and encouragement. If he receives this from a nurse he will respond with greater cooperation and more gratitude than she is likely to receive from the average "normal" patient and she will rarely encounter a "difficult" alcoholic patient. It is my pet theory that alcoholics are the same as everybody else, only more so. The big difference is that they seek release from a compulsion that rapidly robs them of their human dignity and that has

only recently been recognized as a disease. The best attitude for a nurse to develop towards the alcoholic is contained in a statement made by Dr. Haggard to a group of physicians. "The alcoholic may be thought of as a child and may best be handled as a child. An appearance of grave respect, deep understanding and broad tolerance, with no recriminations, elicits confidence from the child—and from the alcoholic."

This is not to imply that the average alcoholic is "childish" in his mental capacities, but rather that he is completely confused and immature in his approach to his problem.

The average alcoholic at Knickerbocker is also far from being the "Skid Row" drunkard that anyone who is not familiar with the problem may visualize. There are butchers, bankers, authors, salesmen and executives, all of whom believe that their work is particularly conducive to excessive drinking until they have had a chance to compare notes in "Duffy's Tavern", and most of whom can "make good" in their various fields of endeavor if they can learn how to stop drinking.

A Keen Satisfaction

The intangible dividends to be gained from nursing the average alcoholic are basically the same as those received when nursing any sick person to recovery. However, the satisfaction is apt to be a little keener since the alcoholic's recovery so quickly affects his immediate family, his friends, his employer, and practically all who know him. The alcoholic's gratitude toward the person who has been a part of his recovery is very sincere, and if the recovery continues in the "outside" world, he will frequently return to report on his progress and to repeat his thankfulness.

More and more opportunities are being created for nurses who wish to enter this field by the recognition that is being given to the fact that alcoholism is a disease. Facilities are being established on an ever-increasing scale through the activities of the National Council on Alcoholism and State programs on alcoholism.

Alcoholic wards like the one at Knickerbocker are being founded in many hospitals throughout the country. Alcoholic clinics, unheard of ten years ago, are being opened all over the country. Alcoholism is an ever present and serious problem for the industrial nurse, with recurrent "sinus" complaints, etc. Public Health Nurses are constantly confronted with the problem. An understanding of the problem of alcoholism and the therapies that are available can be of great assistance in meeting such situations. Private duty nurses more often find themselves with full-blown cases on their hands with no clear idea of what to do other than drop the case. A recognition of the fact that it is an illness that can be successfully arrested makes the situation easier to handle helpfully and with a minimum of confusion and embarrassment.

The U. S. Public Health Service has rated alcoholism as our fourth major public health problem and this is an over-all indication of the size of the job to be done and the opportunities for nursing that are available. Nurses who are already engaged in this type of work seem to regard it as a rewarding and pioneering vocation, in the best sense of that word. That is a reward that is well worth the little extra effort it requires to develop an attitude of understanding and sympathy for men and women who have a disease that can never be cured, but can be permanently and happily arrested.

Since alcoholism is regarded as an emotional illness, the

IF your child feels a persistent pain in his right side, probably you would recognize a symptom of appendicitis and call a doctor. If the doctor said an operation was necessary, you could be sure of getting a skilled surgeon. At the same time you would know, without thinking of it, that your child needed love and understanding. If he became difficult and demanding, you would realize it was because he was helpless and in pain. You would, of course, assume that his illness was not your fault and had nothing to do with the way you felt about each other.

But if someone in your family became emotionally ill—a condition often referred to as mental illness or nervous breakdown—what would you do? Would you recognize the symptoms and know how to get help? Would you know what to expect or how to react? Perhaps you wouldn't.

Yet emotional illness is the most common illness in America. It is a problem that faces—literally—every fifth family. It is more widespread than polio, heart disease or cancer. The people who suffer from it make up a real cross section of America—farmers and city people, the rich and the poor, manual and white-collar workers, the highly educated and those who never attended school.

Despite the fact that emotional illness is so prevalent, it sometimes

HOW TO HELP THE FAMILY OF THE *Emotionally Ill*

by

Karl R. Buetner, M.D.

And

Nathan G. Hale, Sr.

From "Emotional Illness: How Families Can Help"
by Buetner & Hale, G. P. Putnam's Sons, New York

alcoholic's family will surely want to read this article

causes more needless shame and worry than physical sickness. Many people believe it is harder to accept and understand. Yet, it can be faced with the same kind of common sense you would have at your command if your child did develop appendicitis—or, in a harder instance, severe polio.

If a member of your family does become emotionally ill, you, by knowing more about this kind of sickness, can play a vital role in his recovery.

To help him best and to help your own peace of mind you will want to know the answers to many questions that often have occurred to families faced with the problem.

Probably you will want to know how emotional illness differs from ordinary physical illness, what your relative's chances for recovery are, how he may act toward you and how you may most helpfully act toward him. Remembering what you have heard or read, you may, for instance, wonder about whether you are partly responsible for his sickness.

Questions like these may run through your mind: How can I choose a good psychiatrist or a good hospital? What is his sickness about? Why does he seem to hate me? Am I to blame? Why won't he do as I say? How do I know when he is recovering? What can I do to help him get well?

(Continued on page 18)

"IF I TAKE A D

OR, THE ALCOH

I am an alcoholic. I've been thinking of all it would cost me if I took a drink today . . . Strangely enough, I find that the longer I go without a drink, the greater the cost of taking one will be. If I take a drink today, I'll get into the YMCA some time after the bars close tonight, fairly drunk, for I won't take just one drink, and about seven tomorrow morning I'll go to work, feeling guilty and nervous and with a foggy brain. If no one questions my actions, I'll probably struggle thru the day, but certainly no later than 5 PM and then I'll head for a bar—**"if I take a drink today".**

The next night I'll be so drunk I'll be afraid to go into the YMCA (I almost got kicked out of there before). So, when the bars close I'll end up . . . in a high-priced room where I'll stay until my funds run low. On the third or fourth day I'll still be at the hotel, paying exorbitant prices for things I don't need and the bellboy on the way up to my room with a drink will meet another on the way down with empty glasses, for as long as the money holds out, the drinks will keep coming. Who knows? I might stay in there a couple of weeks—until they kick me out—**"if I take a drink today".**

text from

From here on, it is hard to predict just what will happen. I may be working in a restaurant or my present employer may take me back, reluctantly, and give me another chance at a reduced salary with all prestige, seniority and confidence wiped out (that's what happened last time). Then I'll begin sneaking into the YMCA to get things to pawn—first my radio, which I enjoy so much and which I had a hell of a time getting out last time; then, first one suit and then another until there is nothing left but what I have on my back, if I have even that—**"if I take a drink today."**

But at the very best I can only be back to work under reduced earnings and restrictions. I doubt that I'll have my room at the "Y"—I'll have all those debts to pay back, including a doctor's bill. What clothes I have left will be too large, for the 15 pounds I have gained in the past few months will have been consumed in alcohol; all those who I can now call friends will be skeptical at best and with very good reason to be. I'll get back with the old drinking gang just to have some company and then things will start going from bad to worse until I decide I have to quit—**"if I take a drink today."**

By this time I'll be very nervous and concerned about avoiding people I know. I'll probably go to my room at the "Y" some morning and clean up, but things will run along like this several days until the quite a few dollars I now have in my pocket will have dwindled to only a few. Those of you whom I may have met and who might have tried to pull me out of it will have given me up and I will be left entirely alone. My wife, by the absence of mail from me, will know what has happened and all the confidence she has built up in me these past several months will be gone **"if I take a drink today."**

Realization of these things will only cause me to drink more and faster, and within a couple of weeks after that first drink, I'll have moved to cheaper quarters, and soon my funds will be all gone, and I'll start borrowing—ten here, five there, at first, then two and one, until I can't borrow any more. And when that happens, I'll just sit around bemoaning my fate—thinking how rough life is and how mistreated I am. My old resentments and hostility will start building up again and I'll lose whatever constructive thoughts I might once have had—**"if I take a drink today."**

However, regardless of what kind of recovery I might make, with the things I absolutely know it will cost me—THE PRICE IS JUST TOO GREAT. I know it will cost me every dollar I have now and what I can borrow, in addition to the loss of income, totaling in all, seven or eight hundred dollars. I know I'll suffer the pangs of hell, wherever I am, both mentally and physically. I know I'll lose the encouragement and respect of my wife, and my employers and associates will speak and think of me in terms of doubt, at least temporarily—**"if I take a drink today."**

Since I started thinking about what just one drink would cost me, a lot of good things have happened to me that just would not have happened if I had taken that drink. My wife has spent a grand two weeks' vacation with me—the first time we've been together for more than 24 hours for six years. My brother and his wife have been here to visit me—the first time in nine years—and I've had a week's vacation with pay at the boss's cottage with my wife. I've seen several good ball games, a couple of circuses and numerous other things—none of which would have happened **"if I had taken that drink."**

(Continued from page 15)

These are the practical questions this book tries to answer.

First, emotional illness is in these respects like any other kind of sickness: the emotionally ill are helpless and suffer as do people who are acutely ill physically. They act in definite ways for definite reasons. They can be helped. As a statistical rule, they tend to get well. Above all, no one as a deliberating person tries to cause emotional illness in someone they love. You are not to blame for your relative's emotional illness.

But emotional illness does present special problems that differ specifically from those of physical sickness. One of the first problems for you to consider is this.

Whole Family Affected

When emotional illness strikes someone close to you, it can be in its way almost as hard on you as it is on the patient, unless you know what to expect. For the way your relative acts may make it difficult to get along wih him, to have the kind of relationship with him that you desire and that he needs. Second, families tend to become involved in a special way with an emotionally ill relative.

Why does emotional illness create all these particular problems? What is this kind of illness? Basically, it means that your relative's feelings, his attitudes, his emotions, have become so overwhelmingly painful that he no longer can care for himself very well or carry on his ordinary life.

His symptoms very likely will be these: He will be worried and depressed. He may drop friends and social contacts to stay by himself. He may become filled with imaginary and strange ideas. He may try to act impulsively. He may even threaten to harm himself or others in some cases. He may become so overexcited he wears himself out with activity . . .

In a mild form, any of these ways of acting can occur in anyone, particularly at times of emotional crisis or physical sickness. In itself, these signs do not necessarily mean emotional illness. But if the total pattern of your relative's actions becomes consistently unusual and interferes with his ordinary life, then emotional illness may be involved.

If he is emotionally ill, probably you will find that both of you are undergoing a series of special reactions.

At first, hoping nothing serious is wrong, you may try everything you can to cheer him up. You may reason with him or tell him how much you love him, but he won't appear to believe you. You may ask what hurts and troubles him; he may not tell you or else he may insist that nothing at all is the matter. Some days he may seem like his usual self. Then may come days when he seems a strange, different and frightening person.

Wall of Hostility

As he becomes consistently less himself, it may seem as if a wall is rising between you, shutting you off from each other. You may become aware that your relative is sensitive to things that wouldn't bother the average person. Or, you may find that he seems to be deeply angry, apparently hostile toward you. After you have done your best to help, he may turn on you and accuse you of hurting him.

Anyone would and does find situations like these difficult to meet. But relatives tend to feel them with special force for special reasons. The closer a relationship is, the deeper

become all the feelings that surround it; feelings of pleasure and affection are likely to be as intense as temporary feelings of pain and dislike. If the patient is someone you have been accustomed to love and admire, whose good qualities you have valued, or whom you've depended on, you will tend to take all the conflicts of his illness to heart as if they were your own. If in a moment of anger he says he hates you, you may feel it as a blow against your own emotional security. You may begin then to exaggerate your own every shortcoming and question the rightness of all your own decisions. You may come to feel that his illness is somewhat your fault. Indeed, your relative may blame you openly for it.

You may worry about whether he gets the right care—a worry that is less common in physical illness. You may come to feel you can't do too much for him, or object to anything he says and does. You may believe you must satisfy his every demand and then find yourself doing far more than you want to do or feel like doing.

You may discover that in spite of yourself occasionally you get angry at him and resent him. Because of the way he acts and because you are so sensitive to his own conflicts, you may be unable to give him the help you wish to.

During the past half century, much has been learned about the roots and patterns of emotional illness—one of the last areas of human behavior to be studied scientifically. Though much remains to be explored, particularly the exact relation between feelings and bodily functions, far more basic knowledge and agreement has been reached than many of us realize. Treatment methods are more effective than ever before. A recent study at California's Stockton State Hospital showed that by using intensive modern skills a larger percentage of patients who had been given up as "hopeless" and who had been chronically sick for as long as twenty years could be made well enough to return home.

Psychiatrists seldom will describe any case as "hopeless." But the degree of recovery does vary for each individual. Some people become even better adjusted than they were before their illness. Others do not.

Second, the doctor said, emotional illness can be faced with everyday common sense. It is nothing to be ashamed of—yet a family may have to take certain prejudices into account. Some people are still as narrow about emotional illness as they were about tuberculosis and often still are about venereal disease. So, to unsympathetic outsiders, the wisest course may be to say as little about your relative's sickness as seems consistently practical. Often, referring to it as a simple nervous breakdown is enough.

Much of the prejudice against emotional illness comes from the fact that its elements, in fraction, are so very much an unrecognized part of our daily lives.

We all know something about emotional illness from our own experience, but usually without realizing it. Our feelings center around how we come to terms with our-

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A small town minister was greatly shocked to see his wife with her hand in the church collection box.

"Martha, what are you doing?" he exclaimed.

"What do you think I'm doing," she replied. "I'm looking for a button to sew on your coat."

selves and how we relate to other people. In the course of a lifetime nearly all of us share to some degree the feelings that grip the emotionally ill—yet without actually becoming ill ourselves.

We may find problems and conflicts that no amount of effort or will seems to resolve. To a degree, we all have "blue moods". Many of us save up anger, then lose our tempers and hurt people we actually love, or take out hatred on the innocent bystander. We can feel too excited to slow down or too paralyzed by worry to make a required move, or even any move at all. We can be overly touchy about what seems to reflect on our security, quick to take offense. At times we want to get away from people. Then again, we all daydream about things as we would like them to be. Occasionally, we let our emotions overwhelm our sense of reason, fitness and reality.

For most people these moods are neither intense nor lasting. But they are there, none the less, and we have all shared them. A human being without conflicts, always and completely happy, probably has existed only in the imaginations of the miserable. And, in fact, the scale from emotional health to emotional illness is neither absolute nor clear cut. The test, perhaps, is how people function in their daily lives. Many suffer severely from emotional problems, yet muddle through, often paying a heavy toll in unnecessary unhappiness and unproductive pain; these are what psychiatrists call neurotics.

In others, however, emotional problems can create, for a number of interlocking reasons, a nightmare web of reactions involving the entire personality. When people's feelings consistently cripple their ability to care for themselves, fulfill reasonable obligations or relate at all to other people, the question becomes one of more serious illness, sometimes requiring hospitalization. Yet the wildest fantasies of the emotionally ill, or the rigid withdrawal of certain types of patients, for example, represent blighted and desperate attempts to deal with the difficulties of living.

So, fundamentally, our difference —the difference between being emotionally healthy and emotionally sick —remains largely a matter of degree. The emotionally ill represent no strange race apart. They are our own flesh and blood caught in a prison of their own painfully overwhelming feelings.

A Vital Contribution

Finally, your own understanding of the outer edges of emotional illness from your own experience can help you make a vital contribution toward your relative's recovery. A patient's family and friends are the closest ties he has; they are the people he has lived with, the ones who mean most to him. Every family wants to have a workable relationship with an emotionally ill relative, but often finds trouble establishing one. The kind of give and take that makes ordinary situations happy and tolerable is the best way you can help. It should be the sort of relationship that leaves you both able to express your feelings more fully—your feelings of affection as well as those of occasional irritation or dislike, that leaves you both more tolerant of each other's strengths and weaknesses, more happy and secure.

Today, on the basis of a generation of experience, many psychiatrists insist that every emotionally ill patient who does recover successfully does so with another human being's help and understanding.

ABSTINENCE IS NOT SOBRIETY

BY CLAIRE CHENEY

Contrary to the popular view, the alcoholic who is abstaining is not necessarily sober.

HOW often we hear the term, dry drunk, yet I wonder how many of us know exactly what a dry drunk is. Certainly the term seems incongruous, for how can you be dry, that is, not drinking, and drunk at the same time? Yet, there is a very good reason for putting those two words together and perhaps "dry drunk" describes perfectly a condition which many recovered alcoholics, unfortunately, suffer from; abstinence and not sobriety.

When an alcoholic first goes off liquor for a period of days or weeks, he is abstaining. To have given up the bottle at all is a real and significant accomplishment. He cannot be expected to begin looking for real sobriety so soon. It is enough that he is merely abstaining.

But if he stays off liquor permanently, he will want to find happiness with his new state of affairs. He will try through AA, psychiatry, or what-have-you, to achieve some sort of sobriety, that is, peace. It will not be enough to him just to stay dry and sobriety to him will mean more than just abstinence. It will mean inner peace, serenity, a coming together of his emotional, physical and spiritual life.

Don't Understand

Some alcoholics, however, don't know what you're talking about when you speak of this sort of sobriety. They have not developed enough in their new way of life to understand how you can be happy, though sober. To them, it is a constant struggle to keep from returning to the bottle . . . not just a wishful thought every now and then . . . but a minute-by-minute test of their self-restraint to keep from going into that bar, or buying that fifth. How could they possibly be happy when living in such a state of anxiety? Their emotions are constantly being wracked by their psychological need for the dulling effects of alcohol. They have had the alcohol taken away from them, but they are not putting something of value in its place. If they are in the AA program, they are not really using or absorbing it. If they are in psychiatry, they are not truly benefiting

from what it has to offer. If they began their period of abstinence through religious converson, they have failed to keep working at their faith. They are not sober. They are abstainers.

You might meet the abstainer anywhere a group of recovered alcoholics are together. He's usually the loud, boisterous one at the next table. The glad-hander who loves everybody and must shout at you his devotion. The one who talks so much of how wonderful it is to "be sober", speaks in glowing terms of his new way of life, and tells everyone, again in a loud voice, what a stinker he was when he was drinking. But you notice how his hands tremble when he lights his cigarette and the look of frenzy and desperation in his eyes while he tells you of his extreme joy.

The sober one on the other hand is content to let someone else have the spotlight. Oh, he can be loud and back-slapping, too, but he hasn't made a profession out of it. And he needn't tell you in loud words of his happiness. You feel it. He has around him an aura of love and serenity. He is at peace with himself, and so he is at peace with others. He is happy in his sobriety.

Abstainers

The dry drunk and the alcoholic who is merely abstaining are considered to be one and the same—a person whose whole life is as upside down and distorted as it was while drinking, yet who has not touched a drop for quite some time. A dry drunk was once described as a person to whom even so trivial a matter as his wife leaving the cap off the toothpaste tube convinces him that she no longer loves him, and has ganged up with the rest of the world in a preconceived plan for his entire ruin. Although physically he may appear to be perfectly calm, inside he is experiencing the "shakes" and "staggers." His old nervousness and belligerency, so common while drinking, return, even though his strongest beverage may be only coffee.

One dry drunk we know hasn't touched a drop in five years, yet his wife continually hauls him up before the judge and charges him with assault. Is this man sober?

Sober or Not?

Another one, John B., changes jobs as often as the moon does. He claims no one understands him and that his work is not appreciated. The fact is he thinks he's too good to work and the world owes *him* a living. Is he sober?

One of the town's most public-spirited citizens was at one time the town drunk. He's been in AA twelve years and when he quit drinking he joined every club and service organization in town. Now he's so busy attending meetings that his wife and children regard him as a total stranger. What's more, those clubs and organizations are getting tired of his taking over every meeting and running things *his* way. Do you think this man is sober?

But here's another case entirely. Ann L., for years was a "hidden drinker", drinking only at home, preferably in the bathroom with the door locked. She's now found sobriety and is one of the most attractive, out-going young women in town. Her husband and two children smile with pride at the mention of her name.

The town mail-carrier who once thought the world was against him, that everybody hated him and showed his feelings with his uncontrollable temper, is now the friendliest, most easy going postman on the route. Even the dogs love him! AA and psychiatry have shown him a new way of looking at people . . . and

life.

Dick C., once called the life of any party, used to down eight or ten drinks in a single evening's entertainment. With each drink his voice rose louder and louder, his manner became more and more familiar, and the other guests became more and more embarrassed. Soon, Dick wasn't being invited out at all. It simply wasn't fun when he was around.

But now that Dick is dry, he has learned why it is always necessary for him to be the center of attention, and knowing his motives for his inconsiderate actions has lessened their importance. These days Dick is one of the most popular guests around. His ability to move along with the crowd, respecting other people's wishes, holds him in good stead with the host and hostess as well as the rest of the group. Today Dick would certainly not be called a dry drunk. He is sober.

The definitions for abstaining and sobriety are similar, but not alike. Abstaining is defined as a condition of being habitually temperate. Sobriety is defined as being habitually temperate, quiet or sedate, showing self-control.

It would seem then to find sobriety, the alcoholic must first abstain. But with work, therapy and self-knowledge, he will find his goal; sobriety. Abstinence alone is not enough; it is not sobriety. But it can lead to it. And being truly sober will mean to the alcoholic that he has found a maximum of inner peace with a mimimum of inner turmoil.

AL-ANON FAMILY GROUPS IN NORTH CAROLINA

Town	Phone	Box No.
Asheville	3-3187	P. O. Box 1845
Charlotte (Hawthorne)	FR 5-5335	
(Myers Park)	FR 7-5506	
(Roswell)	EM 6-1596	
Cullowhee		P. O. Box 102
Franklin	463 J	P. O. Box 651
Goldsboro	4551 J	
Greensboro	2-6522 or BR 2-8888	
Hendersonville	3-7216 or 3-6823	P. O. Box 434
Jacksonville	6523	
Laurinburg	CR 6-1857	
New Bern	5385	P. O. Box 814
Raleigh	TE 4-8675	P. O. Box 2623
Rockingham	4941 or 2178	
Salisbury	857 J	
Sanford	3-1496	
Winston-Salem	PA 5-2359 or PA 5-6031 or 5-0533	

There are groups also located in Maxton, Statesville, Burlington, Newport, Wilmington, and Whittier. This is the most up-to-date list available, although other Al-Anon groups are continually being formed.


pugh

THERE is something new and hopeful in the heartbreak world of alcoholism. It's an organization called Al-Anon, a sister group to Alcoholics Anonymous, and it exists not for the problem drinker himself, but for the wives, husbands, children, parents, friends—anyone who must live with an alcoholic.

Sylvia B. is typical in many ways of the people for whom Al-Anon was founded. Her husband had been a problem drinker for eleven years. For five of them she did not buy a single new dress. Bob was too expensive. She paid damages twice to keep him out of jail (one smashed window, one wrecked car.) To keep him out of the state hospital, she took a job and sent him to private doctors.

Every time he sobered up, Bob thanked Sylvia with tears of gratitude. He would promise her the world and she would buy him a new suit of clothes. Sometimes he hocked the suit that week, sometimes not for a month or more. Then she would resume her nightly patrol of park benches. Home by cab: "He's not feeling well, driver." (Hoping it wasn't the same one as last week.) Up the front steps (twelve of them). Clean up the mess. Beg. Reproach. Threaten. Her whole life was devoted to Bob's drinking.

The fact that she herself needed help with the hard job of being an alcoholic's wife never occurred to Sylvia. But then one night when she was asking an AA friend once more to talk to Bob, the friend interrupted gently:

"Sylvia, you or I or nobody else can talk to him 'til he wants to listen." He went on before she could speak. "At our last AA meeting we had a speaker from Al-Anon . . ."

Sylvia hardly heard the rest. A new group! To her that meant one thing: *this* group might have the secret of changing Bob. She went to an Al-Anon meeting.

When she walked into the basement room of the church where it was held, seven women, three men and a teen-age boy were sitting around a large table. They all introduced themselves to her—using their

Al-Anon —

SISTER GROUP TO A A

BY ELIZABETH SHERRILL

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Guideposts Associates, Carmel, N. Y.

● *The crisis came when she left her husband asleep on the steps*

first names only—and the meeting continued. One by one, around the table, they talked about the subject for the evening. This week it was prayer: how they prayed, what they were learning about it, what the stumbling blocks were.

For nearly an hour Sylvia listened in astonishment. No one talked about how to make an alcoholic stop drinking. Alcohol was never mentioned. These people were not discussing someone else's problems, they were discussing their own!

After an hour everyone stood up and two of the women began passing coffee and cake. A white-haired lady came up to Sylvia.

"I know it's confusing the first time you come," she said. "We're working on the Twelve Steps of AA, you see. We're on the eleventh step now—that's the one when we try to get close to God through prayer."

"I know all about the Twelve Steps!" Sylvia protested. "I've tried over and over to get my husband to follow them. But they're for alcoholics, not for us!"

The older woman put a gentle hand on Sylvia's arm. "Believe me, my dear, we need them as badly as they do." And over coffee, she told Sylvia the story of Al-Anon.

Unknown Beginning

Nobody really knows when Al-Anon began or who started it. More than ten years ago little groups of men and women were already meeting in different parts of the country to face a common need. These people had discovered that the long years of living with an alcoholic had left scars on their own personalities—some so deep that they remained even when the drinking stopped. The alcoholics had found help in AA; now the families of these alcoholics sought help.

Soon the scattered family groups began to correspond and today there are more than 1,000 groups representing all 49 states and 20 foreign countries. But for all this mushroom growth, Al-Anon is not a "big" organization; it has no president, no rules, no dues, no set pattern for meetings. It remains what it started out to be: men and women getting together because they themselves need help.

And they find it, as Sylvia discovered to her amazement, the same way alcoholics do: through the twelve Steps of AA. The first step says:

We admit we were powerless over alcohol—that our lives had become unmanageable.

Fruitless Nagging Stops

For the alcoholic, this realization is essential to everything that follows; without it he cannot be helped. But in a special way it is also the essential first step for the alcoholic's family. Like Sylvia, most people who love an alcoholic believe that *they* can somehow make him stop drinking. They try pouring his liquor down the sink. Warning local bars not to serve him. Rationing his money. Pleading and bargaining with him. With the first step in Al-Anon all such activity ceases.

The second step is equally important!

We came to believe that a Power Greater than ourselves could restore us to sanity.

"Let Go and Let God", is the profound wisdom learned at Al-Anon. The last ten steps are a spiritual journey out of self-pity, self-righteousness—whatever one's personal shortcomings—toward a knowledge of God *as each one understands Him.*

To know whether a spiritual approach to such a problem works, you have only to drop in on an Al-Anon meeting. You have to hear the

laughter, feel the sympathy, see the love in action—and reflect that each of these people has had tragedy in his family.

But no longer are they facing it alone. Here is a roomful of people who've been through it all. "So many of us, right in this town!" is the typical reaction. People soon begin to hold up their heads again. After a few meetings women often give a little extra attention to their hair; men shine up their shoes. One woman who ate candy whenever her husband was on a spree took off over 30 pounds in her first four months at Al-Anon.

"I not only look like a human being again," she said, "but I'm so weak from dieting I don't have the strength to nag at John and he's started staying home."

Door Opens to AA

Time and again after a husband or wife joins Al-Anon, his alcoholic partner joins AA and stops drinking for good. This is not the purpose of Al-Anon. But it is so often a result that there seems to be only one way to explain it. The alcoholic personality will often lean his whole weight on any support that is offered him. When that support is withdrawn he may find he can stand alone. The Al-Anon member learns to leave the problem to his alcoholic partner. And this can be the shock that starts him on the road to sobriety.

It worked that way for Sylvia. She left that first meeting feeling a little hurt. She'd come to discuss Bob's problem; instead, people suggested she work on *hers*. Like many newcomers to Al-Anon, she couldn't see much to criticize in her own behavior—she might not be perfect, but she'd kept things running, hadn't she?

But as weeks passed, she began to wonder—was it possible she ran things too well? She asked Bob to face facts and then she faced them for him.

The great moment came on a warm spring evening about four months later. She came home late from a meeting to find Bob asleep on the front steps. He had a doorkey in his hand, but hadn't gotten it and the keyhole together. Sylvia took out her own key, stepped over her husband and let herself in.

"I went to bed," she recalls, "Slept fine, too."

The next morning as she was getting breakfast, Bob walked into the kitchen. "What time did you get in?" he demanded.

"About 11:30"

"Where was I?"

"Sleeping on the steps."

Bob blinked as though he were trying to understand a foreign language. "Why didn't you pick me up?"

Sylvia poured him a cup of coffee, looked him in the eye and said,

"Because I didn't put you there."

A New Beginning

For Bob, the shock of losing a support he had so long counted on was the beginning of a new life. Within six months he was in AA and today he and Sylvia tell their remarkable story together at Al-Anon meetings around the country.

The point Sylvia likes to stress is that even before Bob found his own solution, she had found something priceless in Al-Anon. "It's not that I didn't believe in God before," she says. "I prayed all the time."

But she had prayed first for Bob to stop drinking. "Until that happened I didn't see how there could be any happiness for me."

At Al-Anon she learned to ask God what his plan for her happiness was. "It was better than the best I knew how to ask for."

AS HEALTH EDUCATORS —

WHAT CAN WE DO?

Changing the public's attitudes about alcoholism
— this is the educator's most difficult task.

THERE is general agreement that an effective program of education directed toward prevention of alcoholism in our society is needed, but the development of such a program presents difficulties.

Education in any area of health involves development of procedures which will encourage people exposed to a disease to recognize symptoms and to take constructive action. Action may involve individual medical examination, mass immunization, and elimination of the sources of the infection.

Health education specialists have demonstrated that providing information does not necessarily move people to act. This is particularly true when the recommended action is contrary to traditional beliefs regarding an illness or a condition. There are numerous examples of this. In the early years of the present century when tuberculosis was believed to be a disgrace, patients were hidden from the public view by families and friends, and treatment delayed. As community attitudes changed and the nature and treatability of the disease became recognized, effective preventive measures were established. In the field of mental health, public resistance to the concept of emotional and mental illness and to psychiatric treatment has retarded the establishment of comprehensive treatment resources.

Health education must be concerned not only with disseminating factual information about symptomatology and treatment, but also with

From "Problem Drinking & Alcoholism," H. D. Kruse, M.D., Editor

the underlying attitudes, motivations and needs toward which the education program is directed. This factor is particularly significant in prevention of alcoholism.

For more than a decade, we have publicized the concept of alcoholism as a disease. Most alcoholics and their families accept this. Some members of some professional groups—physicians, nurses, social workers, clergy—concede that the alcoholic is sick. But there is considerable disagreement about the nature of the illness. Is it physiological, emotional, social in origin, or is there a combination of all three factors in some alcoholics? Why do alcoholics not respond to the medical techniques effective in most diseases, e.g., hospitalization, diagnostic work-up, medication? Why do alcoholics appear to respond favorably to Alcoholics Anonymous, which is a non-medical program?

Reconcile Theories

These and related questions present a challenge to the specialist in the field of alcoholism. The apparent contradictions in etiology and differential response to clinical treatment offer stimulating material for research. However, when the health educator attempts to formulate a program which defines alcoholism as a disease, he must reconcile the conflicting theories in a descriptive statement acceptable to the general public.

Preventive measures presumably will be directed toward the more than 60 million users of alcoholic beverages who are not alcoholics. Beginning drinkers, regular social drinkers, and heavy excessive users represent the soil in which alcoholism is nurtured. The interrelation of drinking, drunkenness, and alcoholism has not been clearly defined. All alcoholics are drinkers, but not every individual who becomes intoxicated is an alcoholic.

The use of alcoholic beverages is widely accepted in our society. Drinking to intoxication is not frowned upon in some groups, although drunkenness is condemned, even considered immoral by others. The potential alcoholic who begins drinking in a social setting and whose intake increases in amount and frequency progresses to other groups who do not question or condemn his behavior. Indeed, ability to hold one's liquor carries certain prestige in some circles.

Abnormalities Appear Early

There is agreement among specialists in alcoholism therapy that symptoms of abnormal response to alcohol appear early in a drinking career. Among the very early signs of an abnormal response to drinking are: drinking to "meet situations," morning drinking, fortifying oneself with a few drinks before attending a party for fear that the host will have an insufficient supply or will fail to offer a sufficient number of drinks, creating opportunities to take an extra drink without others' knowledge; and drinking more and more often. Following these very early signs will appear the more noticeable ones of repeated intoxication, severe hangovers, blackouts, and seeking intoxication frequently for its anesthetic effect—all these symptoms can be identified before social disorganization sets in. These represent the first stages of alcoholism, yet they are ignored or considered humorous by many heavy drinkers.

Before a program of prevention can be developed, certain fundamental issues must be resolved:

1. Alcoholism, the illness, must be defined and decribed in terms understandable to the lay person. The loose generalizations and assertions

that are publicized at present have little meaning for the average abstainer or user who is not an alcoholic.

2. The millions of users of alcoholic drinks must be encouraged to take a look at their own drinking and their attitudes toward the potential relation of social drinking and alcoholism. Prevention and preventive medicine are broad terms in various usage, covering the range from prevention of death, of the final stages of the full-blown disease, to prevention of the earliest signs. It is the latter which is the ultimate achievement. It carries with it the assumption that the disease is an entity with recognizable signs in its early stages. At present, we identify alcoholism only when the illness is far advanced, often in the crisis stage.

3. An educational program must recognize the strong and conflicting attitudes in our society toward alcohol. Fact-finding questions about social drinking are often rejected as being condemnatory or an attempt to re-establish prohibition. On the other hand, investigation of drinking practices which do not threaten society are objected to by some who would eliminate alcohol entirely. American drinking customs are changing. More people are drinking than in the past, women as well as men, but individual consumption of absolute alcohol is lower than was the case a generation or two ago. There is some evidence that young people in the age range 17-24 are participating in "social drinking" to a greater degree than was thought to exist in the past. Alcohol is not the primary cause of alcoholism. But alcohol plus the factors x, y, and z appear to produce a reaction which facilitates the development of uncontrolled drinking. If awareness of the first symptoms of loss of control can be implanted in the minds of drinkers and these can be accepted as responses which do not reflect on the integrity or character of the individual, it may be possible in time for people at this stage to seek medical advice. This is the logical approach to early symptomotology in any disease condition. But most Americans do not respond logically to questions about alcohol and alcoholism.

The formulation of preventive education on alcoholism calls for application of the specialized skills of the professional health educator. The program will be directed not only toward the public at large but also toward the members of the healing arts who are in a position to advise and direct the individual who exhibits the first signs of alcoholism.

Mass Media Important

Pamphlets, brochures, news releases, radio and television programs —all are important. However, the degree of effectiveness of the mass media in modifying attitudes in a controversial area is subject to question. Certainly in respect to alcoholism publicity, no systematic evaluation on a controlled basis has been conducted. Experience in other fields of health demonstrates that small group discussions are most productive in modifying attitudes. Because drinking is a group practice, it would appear reasonable to undertake initial analysis of drinking customs through the group itself. And this approach probably should be organized and conducted not by recovered alcoholics and specialists in alcoholism treatment, but rather by representatives of public health agencies who have no vested interest in the field except to encourage sound health practices. Prevention of alcoholism is as much a community responsibility as prevention of typhoid or tuberculosis. Yet at pre-

sent, relatively few people in the average community have accepted this responsibility.

Education toward treatment will operate at several different levels. The alcoholic must be persuaded that he should seek treatment. This implies that treatment facilities will be available. In turn, adequately trained personnel interested in working with alcoholics must be recruited. And finally, medical, nursing and social work schools and university departments of clinical psychology must incorporate in pre-service courses sufficient material on the etiology, prognosis, and therapy of alcoholism so that the alcoholic becomes accepted in the community of the ailing. Therapy does not flourish in the climate of the jail and workhouse. In only a few communities at present does therapy of alcoholism flourish in voluntary and municipal hospitals.

If acceptance can be gained that alcoholism, at least in part, is the result of some imbalance in personality development, the possibility of preventive orientation at the social level may emerge. Recovery from alcoholism is the result of a reorientation of emotional forces within the individual. This is true whether or not it takes place in Alcoholics Anonymous, during psychotherapy in a clinic or in a private office, as a result of a religious experience, or spontaneously. Feelings of insecurity, mood swings, frustration often expressed by aggression, withdrawal tendencies—these are experiences common to most people. Although these same reactions are experienced by many people who either do not drink, or drink in a controlled fashion, they appear to be present in exaggerated form among many alcoholics. Because they constitute common ground, they may provide a focus for discussion of psychological factors in the causation of alcoholism.

Certainly the public school has an important role to play in prevention of alcoholism. However, the emphasis should be placed directly on those elements which appear to contribute to progression of the condition. Young people have many insecurities. They have concerns about self identification; they have strong needs for acceptance by their peers. For some, the effect of alcohol on the nervous system provides an extreme gratification proportionate to the psychological needs which exist. If emphasis can be placed on the significance of the reaction to intoxication, if the exaggerated behavior which often appears among young people can be analyzed, and if there can be group discussion and group acceptance of the significance of drinking customs and their possible relationship to alcoholism, it will help in developing attitudes and practices to attain preventive results.

The role of the teacher is of utmost importance. It should appear reasonable to place new emphasis in the teacher-training institutions by incorporating in course work basic information to help them to realize the problems involved in the use of alcohol and to gain understanding of the social attitudes relative to drinking and alcoholism.

Many classrooms contain children of alcoholics. If the school can present alcoholism as an illness, that it is not a sign of weakness and moral degeneration, a definite contribution to the emotional health of many young students can be made. This in turn may contribute to reducing the mass of misinformation and misunderstanding that at present, is prevalent among many adults and may result in a better realization of the psychological factors in causation.

Books of Interest

New Primer on Alcoholism

By Marty Mann
Rinehart & Co., Inc., N. Y.
235 pp.

MARTY Mann's original Primer has almost been entirely rewritten to create this New Primer on Alcoholism. Much of the same material is contained in this book as was in the old, but Mrs. Mann has managed to add a few more facts, anecdotes, and examples of just how alcoholism is fast becoming one of the nation's foremost health problems.

Mrs. Mann, who is currently Executive Director of the organization she helped to found, the National Council on Alcoholism, is uniquely qualified to write a book on alcoholism, for not only has she struggled with it herself, but she has worked since 1944, in this organization which has put her in contact with professionally trained workers as well as laymen.

About this new book, Mrs. Mann writes, "Too many in this great mass of people still do not know the facts about alcoholism, or what to do about it. Too many are still hiding, in fear and shame. It is for them I write, to bring them the latest news—the good news about things *that work.*"

The things that work are, according to Mrs. Mann, Alcoholics Anonymous, Alcoholism Information Centers, Treatment Centers and the National Council on Alcoholism.

About Alcoholics Anonymous, she says, "Alcoholism is compared to diabetes, which makes the individual unable to handle sugar; and the alcoholic to the diabetic, who must learn to give up sugar, adhere to a rigid diet, and take insulin regularly. The AA program, he is told, is his insulin, and he must begin at once to take it, and be prepared to continue taking it for the rest of his life. He is assured that when he learns a little more about it, he will find it very pleasant medicine, indeed, and won't mind in the least."

"The Alcoholism Information and Consultation Center", writes Mrs. Mann, "is not in itself a road to recovery. It is actually a bridge leading to that road, and a very necessary bridge . . . The Center works two ways to provide this bridge: (1) education and (2) services.

About treatment: "Alcoholism, like most other diseases, has two phases; acute and chronic . . . The treatment of acute alcoholism is primarily a medical problem. The treatment of the chronic condition, the alcoholism itself, must remain, in the present state of our knowledge, largely psychological . . . This is a long-term proposition.

The National Council on Alcoholism, with its headquarters in New York City and a network of local affiliates, was founded "to arouse public opinion and to mobilize it for action." The goal was alcoholism education and information and guidance for the alcoholic and those close to him. "NCA is neither wet nor dry and it is not concerned with social drinking. It is a voluntary agency devoted to the disease of alcoholism."

These are the axes that Mrs. Mann has to grind and she is doing all she can to bring these and many other facts about alcoholism into view.

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
615 Wills Forest Rd.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: AL 3-8343
Monday through Friday

Alcoholism Clinic of the
Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: ED 3-5441 & ED 3-5442
Monday through Friday

Forsyth County Program
On Alcoholism
7th & Woodland, Streets
WINSTON-SALEM , N. C.
Phone: PArk 3-2471, Ext. 29
Monday through Friday

Cumberland County
Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: HE 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speaker—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Display—primarily for local public libaries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

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